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| Case Number: | CM14-0157704 | | |
| Date Assigned: | 10/01/2014 | Date of Injury: | 03/27/1993 |
| Decision Date: | 01/21/2015 | UR Denial Date: | 09/20/2014 |
| Priority: | Standard | Application Received: | 09/25/2014 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 44 year old patient with date of injury of 03/27/1993. Medical records indicate the patient is undergoing treatment for acquired spondylolisthesis, lumbar spinal stenosis with neurogenic claudication and lumbar post-laminectomy syndrome. Subjective back pain radiating from low back down left leg, poor quality of sleep, increased axial low back pain with worsening radicular symptoms to LLE, urinary urgency and constipation. Objective findings include lumbar spine range of motion (ROM) - flexion 60 degrees, extension 10, right lateral bending 10, left lateral bending 15, lateral rotation to right 50, to the left is normal. There was paravertebral muscle tenderness and tight muscle band bilaterally; heel toe walk normal, lumbar facet loading positive bilaterally, straight leg test positive on the left, tenderness over posterior iliac spine on the left; light touch sensation decreased on the left over lateral foot, medial calf, lateral calf, medial thigh and lateral thigh. Treatment has consisted of chiropractic therapy, Norco, Naproxen, Neurontin, Tramadol, Ambien, Lamictal and Risperdal. The utilization review determination was rendered on 09/20/2014 recommending non-certification of 1 Lumbar epidural steroid injection and 1 X-ray for the lumbar spine to include 4 views flex/ext.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

1 Lumbar epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections (ESIs), therapeutic

Decision rationale: MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) . . . Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." There were no medical documents provided to conclude that other rehab efforts or home exercise program is ongoing. Additionally, no objective findings were documented to specify the dermatomal distribution of pain. MTUS further defines the criteria for epidural steroid injections to include: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. Radiculopathy does appear to be documented with imaging studies. The treating physician has failed to specify dermatomal distribution either by objective findings or imaging. Additionally, treatment notes do not indicate if other conservative treatments were tried and failed. As such, the request for 1 Lumbar epidural steroid injection is not medically necessary.

1 X-ray for the lumbar spine to include 4 views flex/ext: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Radiography (x-rays)

Decision rationale: ACOEM and ODG both agree that "Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks." The medical notes provided did not document (physical exam, objective testing, or subjective complaints) any red flags for

serious spinal pathology or other findings suggestive of the pathologies outlined in the ODG guidelines. ODG additionally states that "it may be appropriate when the physician believes it would aid in patient management". The treating physician also does not indicate how the x-ray would "aid in patient management". ODG further specifies other indications for imaging with Plain X-rays: Thoracic spine trauma: severe trauma, pain, no neurological deficit
Thoracic spine trauma: with neurological deficit
Lumbar spine trauma (a serious bodily injury): pain, tenderness
Lumbar spine trauma: trauma, neurological deficit
Lumbar spine trauma: seat belt (chance) fracture
Uncomplicated low back pain, trauma, steroids, osteoporosis, over 70
Uncomplicated low back pain, suspicion of cancer, infection
Myelopathy (neurological deficit related to the spinal cord), traumatic
Myelopathy, painful
Myelopathy, sudden onset
Myelopathy, infectious disease patient
Myelopathy, oncology patient
Post-surgery: evaluate status of fusion
The treating physician has not documented evidence of a concern for fracture, recent trauma, or a concern for cancer. The treating physician has not met the criteria for a Lumbar x-ray. However, the treating physician in the 7/3/14 progress note details a concern for bowel and bladder issues (red flag symptoms). Based on these red flag symptoms the treating physician requested a MRI Of the lumbar spine, which would be the appropriate diagnostic test to order. As such, the request for 1 X-ray for the lumbar spine to include 4 views flex/ext is not medically necessary.