

Case Number:	CM14-0194413		
Date Assigned:	12/02/2014	Date of Injury:	03/06/2014
Decision Date:	01/15/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	11/20/2014

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 Internal Medicine and is licensed to practice in California. 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:

The patient is an injured worker with a history of low back injury. Date of injury was 3/06/14. Regarding the mechanism of injury, the patient slipped off the back of a truck. MRI magnetic resonance imaging was performed on 5/20/14. At L3-L4, there is mild to moderate facet hypertrophy, right greater than left. There is no central canal or lateral recess stenosis. There is mild neural foraminal narrowing bilaterally. At L4-L5, there is moderate facet hypertrophy with ligamentum flavum infolding. There is moderate neural foraminal stenosis more so on the left side. There is mild central canal and borderline lateral recess stenosis. At L5-S1, there is moderate facet hypertrophy, right greater than left with mild central canal stenosis. A disc osteophyte complex up to 1.5 mm is seen; more so towards the left with borderline left lateral recess stenosis. There is only mild narrowing of the left neural foramen. The occupational visit progress report dated 9/02/14 documented subjective complaints of low back pain. The patient notes that that she continues to have considerable low back pain and sacral pain. She continues to take pain medications. Physical examination was documented. Pupils are equal and round. There is no facial asymmetry. There is no respiratory distress. The patient stands with an antalgic stance. She has an antalgic gait. The patient moves about the room rather frequently during the extended visit time. The patient remains tender in the lower back and sacroiliac joint regions. There is not foot drop with gait. Assessment was chronic low back pain and sacral contusion. The progress report dated 10/31/14 documented subjective complaints of low back pain. Physical examination was documented. Straight leg raise test was positive on the right side. No appreciable changes in sensory function were noted. Motor muscle strength was normal. Deep tendon reflexes were normal. Diagnosis was lumbosacral radiculitis. Treatment plan was documented. Right L3/4, L4/5, and L5/S1 transforaminal epidural steroid injection times two (x2).

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L3-4 Transforaminal Epidural Steroid Injection under fluoroscopic guidance quantity 2.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural steroid injections ESIs Page(s): 46.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses epidural steroid injections (ESIs). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 300) states that invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Epidural steroid injections treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Chronic Pain Medical Treatment Guidelines (Page 46) states that epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The American Academy of Neurology concluded that epidural steroid injections do not affect impairment of function or the need for surgery and do not provide long-term pain relief. ESI treatment alone offers no significant long-term functional benefit. 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. Most current guidelines recommend no more than 2 ESI injections. Current research does not support series-of-three injections in either the diagnostic or therapeutic phase. No more than 2 epidural steroid injections are recommended. Criteria for the use of epidural steroid injections requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. No more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level should be injected at one session. 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. Medical records document low back complaints. The progress report dated 10/31/14 documented a request for right L3-4, L4-5, and L5-S1 transforaminal epidural steroid injection times two (x2). Per MTUS, no more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level should be injected at one session. Per MTUS guidelines for epidural steroid injections, 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. MTUS indicates that functional improvement must be documented with the first epidural steroid injection in order to support the performance of a second repeat epidural steroid injection. Therefore, the request for epidural steroid injection times two (x2) is not supported. The request for Right L3-4

Transforaminal Epidural Steroid Injection under fluoroscopic guidance quantity 2.00 is not medically necessary.

Right L4-5 Transforaminal Epidural Steroid Injection under fluoroscopic guidance quantity 2.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural steroid injections ESIs Page(s): 46.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses epidural steroid injections (ESIs). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 300) states that invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Epidural steroid injections treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Chronic Pain Medical Treatment Guidelines (Page 46) states that epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The American Academy of Neurology concluded that epidural steroid injections do not affect impairment of function or the need for surgery and do not provide long-term pain relief. ESI treatment alone offers no significant long-term functional benefit. 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. Most current guidelines recommend no more than 2 ESI injections. Current research does not support series-of-three injections in either the diagnostic or therapeutic phase. No more than 2 epidural steroid injections are recommended. Criteria for the use of epidural steroid injections requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. No more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level should be injected at one session. 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. Medical records document low back complaints. The progress report dated 10/31/14 documented a request for right L3-4, L4-5, and L5-S1 transforaminal epidural steroid injection times two (x2). Per MTUS, no more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level should be injected at one session. Per MTUS guidelines for epidural steroid injections, 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. MTUS indicates that functional improvement must be documented with the first epidural steroid injection in order to support the performance of a second repeat epidural steroid injection. Therefore, the request for epidural steroid injection times two (x2) is not supported. The request for Right L4-5

Transforaminal Epidural Steroid Injection under fluoroscopic guidance quantity 2.00 is not medically necessary.

Right L5-S1 Transforaminal Epidural Steroid Injection under fluoroscopic guidance quantity 2.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural steroid injections ESIs Page(s): 46.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses epidural steroid injections (ESIs). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 300) states that invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Epidural steroid injections treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Chronic Pain Medical Treatment Guidelines (Page 46) states that epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The American Academy of Neurology concluded that epidural steroid injections do not affect impairment of function or the need for surgery and do not provide long-term pain relief. ESI treatment alone offers no significant long-term functional benefit. 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. Most current guidelines recommend no more than 2 ESI injections. Current research does not support series-of-three injections in either the diagnostic or therapeutic phase. No more than 2 epidural steroid injections are recommended. Criteria for the use of epidural steroid injections requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. No more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level should be injected at one session. 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. Medical records document low back complaints. The progress report dated 10/31/14 documented a request for right L3-4, L4-5, and L5-S1 transforaminal epidural steroid injection times two (x2). Per MTUS, no more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level should be injected at one session. Per MTUS guidelines for epidural steroid injections, 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. MTUS indicates that functional improvement must be documented with the first epidural steroid injection in order to support the performance of a second repeat epidural steroid injection. Therefore, the request for epidural steroid injection times two (x2) is not supported. The request for Right L5-S1

Transforaminal Epidural Steroid Injection under fluoroscopic guidance quantity 2.00 is not medically necessary.