

<b>Case Number:</b>	CM14-0219023		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	08/18/1998
<b>Decision Date:</b>	03/10/2015	<b>UR Denial Date:</b>	12/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 injured worker is a 63 year old female, who sustained an industrial injury on 8/18/1998. She has reported developing pain in the neck, arms, legs, and back. The diagnoses have included degenerative disc disease, lumbar and cervical nerve root irritability, and bilateral carpal and cubital tunnel syndromes. Prior conservative treatment included acupuncture, physical therapy, home Transcutaneous Electrical Nerve Stimulation (TENS) therapy, postural ergonomics, gym and aquatic programs and oral medication therapy. Treatment to date has also included prior epidural injections documented as effective at relieving pain for approximately one year. Currently, the Injured Worker complains of pain 4-6/10 VAS located in the right shoulder, back and right hip. Bilateral upper and lower extremity strength was documented as 5/5. Diagnoses included degenerative disc disease, cervical spine, chronic low back pain, right rotator cuff syndrome, cervicgia and depression. On 12/16/2014, the Utilization Review certified multiple services including steroid injection to right side at L5 and S1 and certified oral medications. On 12/16/2014 the Utilization Review non-certified a Magnetic Resonance Imaging (MRI) noting no significant changes were documented from prior test completed one year prior, denied left L5 and left S1 epidural steroid injections based on documentation not supporting left sided symptoms supporting medical necessity, and the UR denied radiology for injection based on the request being a duplicate when fluoroscopic guidance is required for epidural injections. The MTUS Guidelines were cited. On 12/31/2014, the injured worker submitted an application for IMR for review of MRI of lumbar spine, Left L5 transforaminal epidural steroid injection, left

S1 transforaminal epidural steroid injection, and radiology for use during a transforaminal epidural injection.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low back chapter, MRIs (magnetic resonance imaging)

**Decision rationale:** Based on the 11/26/14 progress report provided by treating physician, the patient is a 63 year old female that presents with low back pain that radiates to the posterior lateral leg, right greater than left. The patient's date of injury is 08/18/98. The request is for MRI OF THE LUMBAR SPINE. The patient is status post RIGHT L5 and S1 transforaminal epidural steroid injection on 01/02/15, per operative report. Patient's diagnosis on 11/26/14 included lumbar degenerative disc disease and lumbar radiculopathy. Physical Examination to the lumbar spine on 11/26/14 revealed spasm and bilateral paraspinal tenderness. Range of motion was decreased, especially on extension 15 degrees. Positive straight leg raise test on the RIGHT. Light touch sensory exam revealed numbness to RIGHT lateral foot. Patient's medications include Baclofen, Senna, Lyrica and Opana. Patient is continuing with physical therapy, per treater report dated 12/24/14. The patient is permanent and stationary. ODG guidelines, Low back chapter, MRIs (magnetic resonance imaging) (L-spine) state that "for uncomplicated back pain MRIs are recommended for radiculopathy following at least one month of conservative treatment." ODG guidelines further state the following regarding MRI's, Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). Treater has not Per UR letter dated 12/16/14 "MRI was performed approximately one year ago which did not reveal any red flag findings and there have been no significant clinical changes since the previous MRI." According to guidelines, for an updated or repeat MRI, the patient must be post-operative or present with a new injury, red flags such as infection, tumor, fracture or neurologic progression. This patient does not present with any of these. Therefore, the request IS NOT medically necessary.

**Left L5 transforaminal epidural steroid injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Epidural steroid injections (ESIs), therapeutic'

**Decision rationale:** Based on the 11/26/14 progress report provided by treating physician, the patient is a 63 year old female that presents with low back pain that radiates to the posterior lateral leg, right greater than left. The patient's date of injury is 08/18/98. The request is for LEFT L5 TRANSFORAMINAL EPIDURAL STEROID INJECTION. The patient is status post RIGHT L5 and S1 transforaminal epidural steroid injection on 01/02/15, per operative report. Patient's medications include Baclofen, Senna, Lyrica and Opana. Patient is continuing with physical therapy, per treater report dated 12/24/14. The patient is permanent and stationary. The MTUS Guidelines has the following regarding ESI under chronic pain section page 46 and 47, Recommends as an option for treatment of radicular pain." MTUS has the following criteria regarding ESI's, under its chronic pain section: Page 46, 47 "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." For repeat ESI, MTUS states, "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." ODG guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Epidural steroid injections (ESIs), therapeutic', state that at the time of initial use of an ESI (formally referred to as the diagnostic phase as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections. Treater has not provided reason for the request. Per UR letter dated 12/16/14, requests for RIGHT L5 and RIGHT S1 Transforaminal Epidural Steroid Injections were APPROVED. Patient's diagnosis on 11/26/14 included lumbar degenerative disc disease and lumbar radiculopathy. Physical Examination to the lumbar spine on 11/26/14 revealed spasm and bilateral paraspinal tenderness. Range of motion was decreased, especially on extension 15 degrees. Positive straight leg raise test on the RIGHT. Light touch sensory exam revealed numbness to RIGHT lateral foot. The request is for injection to LEFT L5, however physical examination findings pertain to the RIGHT. Guidelines require patient's symptoms to be supported by physical exam findings and corroborated by MRI or electrodiagnostic studies, which have not been provided. The request does not meet guideline criteria. Therefore, the request IS NOT medically necessary.

**Left S1 transforaminal epidural steroid injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic -Acute & Chronic- Chapter under Epidural steroid injections (ESIs), therapeutic

**Decision rationale:** Based on the 11/26/14 progress report provided by treating physician, the patient is a 63 year old female that presents with low back pain that radiates to the posterior lateral leg, right greater than left. The patient's date of injury is 08/18/98. The request is for LEFT S1 TRANSFORAMINAL EPIDURAL STEROID INJECTION. The patient is status post RIGHT L5 and S1 transforaminal epidural steroid injection on 01/02/15, per operative report. Patient's diagnosis on 11/26/14 included lumbar degenerative disc disease and lumbar radiculopathy. Patient's medications include Baclofen, Senna, Lyrica and Opana. Patient is continuing with physical therapy, per treater report dated 12/24/14. The patient is permanent and stationary. The MTUS Guidelines has the following regarding ESI under chronic pain section page 46 and 47, Recommends as an option for treatment of radicular pain." MTUS has the following criteria regarding ESIs, under its chronic pain section: Page 46, 47 "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." For repeat ESI, MTUS states, "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." ODG guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Epidural steroid injections (ESIs), therapeutic', state that at the time of initial use of an ESI (formally referred to as the diagnostic phase as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections. Treater has not provided reason for the request. Per UR letter dated 12/16/14, requests for RIGHT L5 and RIGHT S1 Transforaminal Epidural Steroid Injections were APPROVED. Patient's diagnosis on 11/26/14 included lumbar degenerative disc disease and lumbar radiculopathy. Physical Examination to the lumbar spine on 11/26/14 revealed spasm and bilateral paraspinal tenderness. Range of motion was decreased, especially on extension 15 degrees. Positive straight leg raise test on the RIGHT. Light touch sensory exam revealed numbness to RIGHT lateral foot. The request is for injection to LEFT S1; however physical examination findings pertain to the RIGHT. Guidelines require patient's symptoms to be supported by physical exam findings and corroborated by MRI or electrodiagnostic studies, which have not been provided. The request does not meet guideline criteria. Therefore, the request IS NOT medically necessary.

**Radiology for injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic -Acute & Chronic- Chapter under Epidural steroid injections (ESIs), therapeutic

**Decision rationale:** Based on the 11/26/14 progress report provided by treating physician, the patient is a 63 year old female that presents with low back pain that radiates to the posterior lateral leg, right greater than left. The patient's date of injury is 08/18/98. The request is for RADIOLOGY FOR INJECTION. The patient is status post RIGHT L5 and S1 transforaminal epidural steroid injection on 01/02/15, per operative report. Patient's diagnosis on 11/26/14 included lumbar degenerative disc disease and lumbar radiculopathy. Physical Examination to the lumbar spine on 11/26/14 revealed spasm and bilateral paraspinal tenderness. Range of motion was decreased, especially on extension 15 degrees. Positive straight leg raise test on the RIGHT. Light touch sensory exam revealed numbness to RIGHT lateral foot. Patient's medications include Baclofen, Senna, Lyrica and Opana. Patient is continuing with physical therapy, per treater report dated 12/24/14. The patient is permanent and stationary. ODG-TWC, Low Back - Lumbar & Thoracic -Acute & Chronic- Chapter under Epidural steroid injections (ESIs), therapeutic states: "Fluoroscopic guidance: Fluoroscopic guidance with use of contrast is recommended for all approaches as needle misplacement may be a cause of treatment failure. Manchikanti, 1999" Per UR letter dated 12/16/14, requests for RIGHT L5 and RIGHT S1 Transforaminal Epidural Steroid Injections and Fluoroscopy for Injection were APPROVED. The request for Radiology was denied since it was a duplicate request. Treater has not provided reason for the request. Fluoroscopic guidance is recommended by guidelines for ESIs. The request for radiology would be indicated, however the requests for the LEFT L5 and LEFT S1 epidural steroid injections have not been authorized. Furthermore, per UR letter dated 12/16/14, the requests for "Fluoroscopy" for Injection was APPROVED and "Radiology" was denied, with regards to the requests for RIGHT L5 and RIGHT S1 epidural steroid injections. It appears this is another duplicate request. Therefore, the Radiology IS NOT medically necessary.