

Case Number:	CM15-0175973		
Date Assigned:	09/17/2015	Date of Injury:	04/18/1996
Decision Date:	10/23/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/08/2015

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 78 year old male, who sustained an industrial injury on 4-18-1996. The injured worker was diagnosed as having neurogenic claudication. Treatment to date has included diagnostics, multiple lumbar spinal surgeries, unspecified epidural steroid injections, physical therapy, and medications. Magnetic resonance imaging of the lumbar spine (7-31-2015) showed prior surgery at L4-5 level with interbody fusion, grade 1 anterolisthesis of T12 on L1 with endplate edema, Schmorl's node with acute edema along the right inferior endplate of L5, mild to moderate L3-4 spinal stenosis and compromise of left L3-4 subarticular recess, possibly affecting origin of left L4 nerve sleeve, prominent narrowing of right L5-S1 neural foramen, and moderate bilateral L3-4 foraminal compromise. Computerized tomography of the lumbar spine (7-31-2015) showed advanced multilevel degenerative disc disease and facet arthropathy with degenerative spondylolisthesis at T12-L1. L4-5 appeared to be fused. Also noted was mild to moderate spinal stenosis at L1-2, severe neural foraminal narrowing at bilateral L5-S1, and moderate bilateral neural foraminal narrowing at L3-4. Currently (8-21-2015), the injured worker complains of recently exacerbated pain at the lumbosacral junction and distribution covered by his two palms. He also had pain in his bilateral buttocks and a left lower extremity radiculopathy that ran through his plantar foot, "that has resolved over the past eight months following an epidural steroid injection". His pain was not currently rated. He was taking Oxycontin for the past 8 years, bringing his dose down, and was currently taking 20mg twice daily. It was documented that he had epidural steroid injections in the past and that the "last one helped his

sciatic for the last eight months". It was documented that 2 courses of physical therapy did not help him. Physical exam noted ambulation stooped forward, with the use of a cane. His patellar and Achilles reflexes were absent. Lower extremity strength was 5 of 5. The treatment plan included a right lumbar transforaminal epidural steroid injection at L3-4 for diagnostic and therapeutic purposes, non-certified by Utilization Review on 9-02-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar right transforaminal epidural steroid injection at L3-4 as outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back -Lumbar & Thoracic (Acute & Chronic) chapter under Epidural steroid injections (ESIs).

Decision rationale: The 78 year old patient complains of lumbosacral junction pain, bilateral buttock pain, and left lower extremity radiculopathy running through to plantar foot, as per progress report dated 08/21/15. The request is for LUMBAR RIGHT TRANSFORAMINAL EPIDURAL STEROID INJECTION AT L3-4 AS OUTPATIENT. The RFA for this case is dated 08/27/15, and the patient's date of injury is 04/18/96. The patient is status post L3-4 laminectomy and discectomy in 1987, status post L4-5 laminectomy and discectomy in 2000, status post left total knee arthroplasty, and status post two hernia repairs, as per progress report dated 08/21/15. The patient has been diagnosed with neurologic claudication. Diagnoses, as per progress report dated 07/24/15, included chronic back and radicular pain, and peripheral neuropathy. Medications included Oxycontin and Gabapentin. The patient has retired, as per progress report dated 08/21/15. The MTUS Chronic Pain Guidelines 2009, Epidural Steroid Injections (ESIs) section and page 46 and 47 states: Recommended 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, Low Back -Lumbar & Thoracic (Acute & Chronic) chapter under Epidural steroid injections (ESIs), therapeutic state: 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. In this case, a request for bilateral L3-4 ESI from the patient's spine surgeon

is noted in progress report, dated 08/21/15. However, the request for review is RIGHT epidural steroid injection at L3-4. The reports do not document a prior RIGHT epidural steroid injection at this level. As per the 08/21/15 report, the patient has left lower extremity radiculopathy that runs through his plantar foot but these symptoms were resolved over the past eight months following an epidural steroid injection. When the Utilization Review contacted the spine surgeon requesting the procedure, he stated that the main motivation for the injections is 'to make sure this is the offending level'. The spine surgeon believed that a surgery was indicated and was amenable with proceeding directly with surgery, as there seems to be no medical necessity for injections. MRI of the lumbar spine, dated 07/31/15, revealed degenerative changes at L3-4 along with mild/moderate spinal stenosis, compromise of left L3-4 subarticular recess possibly affecting origin of left L4 nerve root, and moderate bilateral neural foraminal narrowing. As per a neurology progress report, dated 07/24/15, the patient has lower back pain that radiates to bilateral lower extremities. Physical examination, however, revealed a negative straight leg raise. MTUS requires clear indication of radiculopathy during physical examination along with corroborating diagnostic evidence for ESI. Given the negative straight leg raise during physical examination (07/24/15), only LEFT lower extremity radiculopathy (08/21/15), and only LEFT L4 nerve root compromise on the MRI, radiculopathy on the right is not established clearly. Hence, the request for RIGHT L3-4 epidural steroid injection IS NOT medically necessary.