

Case Number:	CM15-0179855		
Date Assigned:	09/21/2015	Date of Injury:	07/16/1999
Decision Date:	10/27/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	09/14/2015

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: Montana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 (IW) is a 56 year old female who sustained an industrial injury on 07-16-1999. Medical records indicate the worker is treated for post laminectomy syndrome and lumbago. Treatment to date has included acupuncture, chiropractic, epidural steroid injections, facet joint injections, and an indwelling spinal cord stimulator. She currently uses Percocet, Soma, and diclofenac. Previous x-rays demonstrate evidence of a lumbar fusion at L3-4 and L4-5. There is intervertebral settling at L5-S1. The worker on July 8, 2015 was seen for severe back pain and pain radiating down the legs. She also has right knee pain. On exam, she has a painful antalgic gait to the right, a negative straight leg raise, and tenderness around her right knee and at L5-S1. In her 05-16-2015 appointment, it was noted that there is no radicular pain at that exam due to the spinal cord stimulator, but diagnoses indicate residual radiculopathy status post spinal cord stimulator placement has been a problem. A request for authorization was submitted 08-28-2015 for Outpatient nerve root block to the left L5 (lower back) and left L5-S1 facet joint. A utilization review decision 09-04-2015 non-certified the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient nerve root block to the left L5 (lower back) and left L5-S1 facet joint: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Epidural steroid injections and facet joint medial branch blocks (therapeutic injections).

Decision rationale: The MTUS states that invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain. The ODG guidelines for facet joint medial branch blocks (therapeutic injections) notes that they are not recommended except as a diagnostic tool, minimal evidence for treatment. Pain Physician 2005: In 2005 Pain Physician published an article that stated that there was moderate evidence for the use of lumbar medial branch blocks for the treatment of chronic lumbar spinal pain. (Boswell, 2005) This was supported by one study. (Manchikanti, 2001) Patients either received a local anesthetic or a local anesthetic with methyl prednisolone. All blocks included Sarapin. Sixty percent of the patients overall underwent seven or more procedures over the 2 year study period (8.4 0.31 over 13 to 32 months). There were more procedures recorded for the group that received corticosteroids than those that did not (301 vs. 210, respectively). ["Moderate evidence" is a definition of the quality of evidence to support a treatment outcome according to Pain Physician.] The average relief per procedure was 11.9 3.7 weeks. Regarding epidural steroid injections (ESIs), therapeutic, they are recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. Not recommended for spinal stenosis or for nonspecific low back pain. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, but ESIs have not been found to be as beneficial a treatment for the latter condition. ESIs are associated with less improvement in spinal stenosis. (Radcliff, 2013) Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. (1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, muscle relaxants & neuropathic drugs). (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. (4) Diagnostic Phase: 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. (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) Therapeutic phase: If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase". Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus. (8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. (9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment. (10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. In this case, the radiculopathy has been corroborated by electrodiagnostic testing. Previous facet blocks and subsequent rhizotomy have been helpful however, it is not recommended to perform epidural blocks on the same day of treatment as facet blocks. As such, the request for outpatient nerve root block to the left L5 (lower back) and left L5-S1 facet joint is not medically necessary.