

Case Number:	CM15-0020348		
Date Assigned:	02/09/2015	Date of Injury:	11/17/2012
Decision Date:	04/14/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/03/2015

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: District of Columbia, Virginia
 Certification(s)/Specialty: Internal 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:

On 11/17/12, this 65-year-old female sustained an industrial injury subsequent ongoing back and right shoulder pain. Magnetic resonance imaging lumbar spine (4/5/13) showed degenerative disc disease, congenital spinal stenosis and moderate right sided disc protrusion impinge on the right L5 nerve root. Treatment included physical therapy, epidural steroid injections and medications. In an office visit dated 12/19/14, the injured worker complained of constant low back pain with pain and radiation down the right lower extremity to the knees and calves. Physical exam was remarkable for a slightly antalgic gait, spasm and guarding at the base of the lumbar spine, limited lumbar range of motion, positive straight leg raise on the right and trace weakness on the right at the extensor halluc longus. Current diagnoses included lumbar disc herniation with right L5 radiculopathy. The treatment plan included transforaminal injection on the right side at L4-5. On 1/26/15, Utilization Review modified a request for one right transforaminal lumbar epidural injections at right L4 and L5, lumbar epidurogram, IV sedation, fluoroscopic guidance and contrast dye to one right transforaminal lumbar epidural injections at right L4 and L5, fluoroscopic guidance and contrast dye and noncertified a request for one EMG of the bilateral lower extremities noting lack of indication for the need for intravenous sedation and citing ODG and CA MTUS Chronic Pain Medical Treatment Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

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

One right transforaminal lumbar epidural injections at right L4 and L5, lumbar epidurogram, IV sedation, fluoroscopic guidance and contrast dye: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792 Page(s): 46.

Decision rationale: Per MTUS: Epidural steroid injections (ESIs) Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a series of three ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. 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 is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three." Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 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. Per review of the clinical data provided, there is evidence that the patient has radicular signs and had

demonstrated improvement following ESI. This intervention would fall in line with the guidelines as cited above.

One EMG of the bilateral lower extremities: Overturned

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, Low Back-Lumbar & Thoracic (Acute & Chronic) EMGs (electromyography).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: Per ACOEM: Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. Diskography is not recommended for assessing patients with acute low back symptoms. Low Back Complaints 303 Table 12-7 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects. An imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for one month or more to further evaluate the possibility of potentially serious pathology, such as a tumor. Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. Magnetic resonance (MR) neurography may be useful in isolating diagnoses that do not lend themselves to back surgery, such as sciatica caused by piriformis syndrome in the hip. However, MR neurography is still new and needs to be validated by quality studies. Per review of the clinical data provided, the patient had ongoing pain from radiculopathy. Further diagnostic would be appropriate.