Case Number:	CM13-0040239		
Date Assigned:	12/27/2013	**Date of Injury:**	03/09/2007
Decision Date:	02/20/2014	**UR Denial Date:**	09/16/2013
Priority:	Standard	**Application Received:**	10/07/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and Pain Management, has a subspecialty in Interventional Spine 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 physician 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 a 47-year-old male, date of injury 03/09/2007. Per treating physician's report, 09/05/2013, this patient presents with mid back, low back, left hip, left foot with radiation into the left leg. The patient has weakness in the left leg and the pain intensity is 3/10 to 4/10 on average. Current listed medications are Lidoderm patches, Neurontin, Nucynta, and nortriptyline. Motor examination showed EHL (Extensor Hallucis Longus) is 4/5 on the left side, dorsiflexion at 4/5 left side. Sensory examination decreased L5 on left side. The treating physician lists the diagnoses of lumbar radiculopathy, post-laminectomy syndrome, low back pain, hip bursitis, and pain in the joint of lower extremity. Under discussion, the treating physician indicates that the patient has history of lumbar fusion from L4 to S1, prior history of spinal cord stimulation placement in 05/09/2009 which was removed in 2011. The patient continues to experience severe neuropathic foot pain secondary to radiculopathy. The patient had prior TFESI (Transforaminal Epidural Steroid Injection) on 05/21/2013 with 40% to 50% pain reduction, and consider repeating left L5 and S1 transforaminal ESI as needed. The treater has recommended left S1 and S2 epidural steroid injection for the left foot pain. The treater also would like to consider S1 joint injections. MRI from 12/09/2013 shows both prior laminectomies and diskectomies at L4-L5, L5-S1, with posterior hardware present. Trivial disk bulge is noted at L3-L4, L2-L3 and L1-L2. Operative reports 05/21/2013 for left L5 and S1 transforaminal epidural steroid injection. Progress report from 05/30/2013 by [redacted] has the patient's pain at 3/10 to 4/10, continued low back pain, mid back pain, radiation down the left lower extremity. Following the epidural steroid injection, significant reduction of pain with pain decreasing from 6/10 to 3/10 to 4/10. Nucynta ER has been able to decrease to 1 per day. 07/11/2013 report by [redacted]

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Lumbar epidural injection, S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS (7/18/09); Chronic Pain Guidelines: Epidural steroid injec.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS, Chronic Pain Medical Treatment Guidelines Page(s): 46-47.

Decision rationale: This patient presents with chronic low back and left lower extremity pain. The patient is status post lumbar fusion from L4 to S1. The patient had spinal cord stimulation implanted in 2009 which was removed in 2011. The patient had an updated MRI of the lumbar spine in 2013 that showed posterior instrumentation, laminectomies, and diskectomies at L4 to S1. Only minor bulging disks were noted at the levels of L1 to L4. The patient continues to experience significant pain down the left lower extremity particularly pain and numbness and tingling around the foot. The patient recently underwent lumbar epidural steroid injection on the left side at L5-S1 levels on 05/21/2013. There are conflicting results reported by [redacted]. His notes from 05/30/2013, 07/11/2013, and 08/06/2013 show that the patient's pain levels have not changed under subjective presentation with an average level of pain of 3/10 to 4/10. This level of pain has remained the same throughout [redacted] notes. However, under interval event, [redacted] notes that following lumbar epidural steroid injection, the patient's pain subsided from 6/10 to 3/10 to 4/10. There are no discussions regarding patient's functional improvement. The patient is noted to be taking less Nucynta down to 1 per day. However, the medications listed under current medications, show no changes. For example on 05/02/2013, the patient's Nucynta dosing was at 50 mg extended release twice daily, and 50-mg tablets 1 daily. 07/11/2013 report has identical medication list with Nucynta 50 extended release b.i.d. and 50 mg q.d. Therefore, the treating physician's statement that the patient is taking less medication is not verified by the list of current medications provided in the notes. MTUS Guidelines recommend epidural steroid injections as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy. In this patient, while the patient continues to experience pain down the left lower extremity, the patient has already had fusion as well as laminectomy. There are no new disk herniations or stenosis that would account for the patient's persistent left lower extremity pain. The persistent left lower extremity pains are likely the residual effects from prior disk injury for which the patient has had diskectomy and fusion. The patient's leg symptoms have been treated with spinal cord stimulation without much success. The patient has had epidural injections in the past without clear documentation of improvement in terms of function and pain. As noted above, the treating physician provides mixed documentation regarding the patient's response. Most importantly, there are no current corroborating imaging study findings that would explain the patient's left lower extremity symptoms or radicular pain. There are no disk herniations or stenoses to account for patient's left lower extremity pain other than postlaminectomy syndrome th

Transforaminal Lumbar epidural injection, S2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS (7/18/09); Chronic Pain Guidelines: Epidural steroid injec.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS, Chronic Pain Medical Treatment Guidelines Page(s): 46-47.

Decision rationale: This patient presents with chronic low back and left lower extremity pain. The patient is status post lumbar fusion from L4 to S1. The patient had spinal cord stimulation implanted in 2009 which was removed in 2011. The patient had an updated MRI of the lumbar spine in 2013 that showed posterior instrumentation, laminectomies, and diskectomies at L4 to S1. Only minor bulging disks were noted at the levels of L1 to L4. The patient continues to experience significant pain down the left lower extremity particularly pain and numbness and tingling around the foot. The patient recently underwent lumbar epidural steroid injection on the left side at L5-S1 levels on 05/21/2013. There are conflicting results reported by [redacted]. His notes from 05/30/2013, 07/11/2013, and 08/06/2013 show that the patient's pain levels have not changed under subjective presentation with an average level of pain of 3/10 to 4/10. This level of pain has remained the same throughout [redacted] notes. However, under interval event, [redacted] notes that following lumbar epidural steroid injection, the patient's pain subsided from 6/10 to 3/10 to 4/10. There are no discussions regarding patient's functional improvement. The patient is noted to be taking less Nucynta down to 1 per day. However, the medications listed under current medications, show no changes. For example on 05/02/2013, the patient's Nucynta dosing was at 50 mg extended release twice daily, and 50-mg tablets 1 daily. 07/11/2013 report has identical medication list with Nucynta 50 extended release b.i.d. and 50 mg q.d. Therefore, the treating physician's statement that the patient is taking less medication is not verified by the list of current medications provided in the notes. MTUS Guidelines recommend epidural steroid injections as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy. In this patient, while the patient continues to experience pain down the left lower extremity, the patient has already had fusion as well as laminectomy. There are no new disk herniations or stenosis that would account for the patient's persistent left lower extremity pain. The persistent left lower extremity pains are likely the residual effects from prior disk injury for which the patient has had diskectomy and fusion. The patient's leg symptoms have been treated with spinal cord stimulation without much success. The patient has had epidural injections in the past without clear documentation of improvement in terms of function and pain. As noted above, the treating physician provides mixed documentation regarding the patient's response. Most importantly, there are no current corroborating imaging study findings that would explain the patient's left lower extremity symptoms or radicular pain. There are no disk herniations or stenoses to account for patient's left lower extremity pain other than postlaminectomy syndrome