

<b>Case Number:</b>	CM13-0050342		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	12/07/2009
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	10/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/13/2013

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine 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 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/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 54 year old female who was injured on 12/07/2009. Mechanism of injury is unknown. Prior treatment history has included acupuncture, aquatic therapy, home exercise program, injection therapy and Medrol Dosepak. On 05/31/2012 and 07/30/2013 the patient had an insertion of a lumbar epidural catheter, epidurogram and L4-5 epidural local anesthetic and steroid injection. Diagnostic studies reviewed include MRI of the lumbar spine w/o contrast revealing loss of intervertebral disc height and disc desiccation changes are seen at L4-5 levels. The L5-S1 level had left greater than right paracentral and left lateral 4.8 mm broad-based disc protrusion with right lateral spinal and neural foraminal stenosis. The L4-L5 level had 3.2 mm broad-based protrusion with mild left spinal stenosis. Progress note dated 09/18/2013 documented the patient received one lumbar spine epidural injection on 07/30/2013 that initially reduced low back pain by 30% and reduced her bilateral lower extremity radiculopathy symptoms temporarily. Patient states that for the past three weeks the left side of her neck and shoulder pain has intensified. Patient denies any strenuous activities contribute to this acute flare-up. Patient states that her neck pain is constant left upper extremity radiculopathy symptoms. Patient received 1 cortisone injection in the left shoulder subacromial space that provided her with 15% decrease in pain. Patient also received a cortisone injection for bilateral carpal tunnel syndrome with no benefit. Objective findings on exam included examination of the cervical spine that reveals tenderness in the left side sternocleidomastoid region, tenderness in the left upper trapezius region and levator scapular region. Examination reveals positive probably compression test with head in the left position, negative on the right. Positive Spurling's test with head in the left position, negative on the right. Examination of the left shoulder reveals diffuse tenderness with tenderness in the acromioclavicular joint region with positive cross body abduction movement. Patient is able to forward flex to 175 degrees. Examination reveals positive

Hawkins's test, positive Neer test. Physical examination of bilateral hands and wrist reveals positive Tinel sign bilaterally, positive Phalen's sign bilaterally, positive Finkelstein test bilaterally. Examination reveals Thenar weakness bilaterally. Examination of the lumbar spine reveals positive straight leg raise in sitting position. There is tenderness in the left side paraspinal muscle region. Urinalysis toxicology collection dated 08/14/2013 reveals inconsistent findings with hydrocodone. The test result reveals that this medication has been prescribed but not detected. The patient states that she takes her analgesic medication on a daily basis. Diagnoses: 1. Cervical/thoracic strain/arthrosis with resulting cephalgia. 2. Bilateral shoulder impingement syndrome with acromioclavicular joint arthrosis and partial thickness rotator cuff tear. 3. Bilateral carpal tunnel syndrome. 4. Status post thermal injury left forearm and wrist. 5. Bilateral de Quervain's tenosynovitis Michal. 6. Lumbosacral strain/arthrosis/radiculopathy. 7. Bilateral knee strain/arthrosis and possible patellofemoral syndrome. 8. Right foot and ankle sprain/strain. PR-2 dated 10/11/2013 documented the patient had epidural steroid injection 07/30/2013 and Medrol Dosepak with overall only 50% better. Patient complains of low back pain radiating into the posterior lateral thigh associated with numbness and tingling. Objective findings on exam reveal positive myofascial trigger L4 especially L4 (2x2 cm). Sensation is decreased in the posterior thigh. Diagnoses: 1) Lumbar radiculopathy. 2) L4-5, L5-S1 disc.

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

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

#### **LEFT L4-S1 LUMBAR EPIDURAL STEROID INJECTION: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46-47.

**Decision rationale:** The guidelines state 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. According to the progress note dated 09/18/2013, the patient received one lumbar spine epidural injection on 07/30/2013, from which she only obtained 30% reduction in back pain and temporarily reduced low extremity radicular symptoms. It does not appear that the patient had optimum response to the prior epidural steroid injection. In addition, the medical records do not establish the patient has been unresponsive to recent attempts with conservative treatment such as exercises, physical methods, NSAIDs and muscle relaxants. Therefore, the request for lumbar ESI is non-certified.