

Case Number:	CM13-0057307		
Date Assigned:	12/30/2013	Date of Injury:	05/08/2006
Decision Date:	03/27/2014	UR Denial Date:	11/04/2013
Priority:	Standard	Application Received:	11/25/2013

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 and Rehabilitation, 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 62 year old male who was injured on 5/1/06. He experienced lower back pain when handling luggage. Prior treatment history has included conservative treatment with physical therapy, pool therapy, land therapy, and the use of OrthoStim and medication. Back surgery was performed in January 2007 by [REDACTED]. He underwent additional surgeries shortly after. The patient underwent a L3-4, L4-L5, and L5 lumbar transforaminal bilateral epidural injection on 7/9/13, providing approximately 50-55% alleviation of his radicular complaints. It has also been beneficial with his mobility and overall functionality. Laboratory analysis performed 6/20/13 revealed detection of Tramadol. Medications documented on unit every four to six hours, Lidoderm patches, Lodine Norco 10/325mg, two a day. Medications documented on 10/16/13 included Prilosec 20mg daily, and Flexeril 7.5mg as a muscle relaxant. Nerve conduction study (NCS) on 5/18/13 revealed normal sensory/motor studies. EMG study revealed normality in all paraspinal and lower extremity muscles tested. An MRI of the lumbar spine with two views performed on 5/22/2013 revealed loss of normal disc height at L2-3, L3-4, L4-5 and L5-S1 levels. An MRI of the lumbar spine performed on 5/17/13 revealed possible spondylolysis and/or pars defects at L3 and L4. There was a 3-4mm disc/facet abnormality at L4-L5 without annular tear/fissure, and a 3mm disc/facet abnormality at L5-S1 with annular tear/fissure. There was nerve root compromise/traversing at L4-5, 3-4mm bilaterally. There was nerve root compromise/traversing at L5-S1, 3mm bilaterally. A clinic note dated 7/22/13 documented the patient to have complaints of constant pain and discomfort in the low back and lower extremities. The pain frequently radiates down the bilateral thigh, leg, and foot, right greater than the left. Prolonged walking and standing worsens his pain. The patient avoids strenuous lifting, carrying, pulling, pushing, stooping, and bending because of the back condition. The patient reported that during the course of the performance of activities of daily

living, there was still a significant amount of pain and stiffness of the lumbar spine and lower extremities. Objective findings on exam included being unable to perform heel and toe walk, loss of lumbar lordosis, tenderness to palpation of the lumbar spine, restricted and painful range of motion of the lumbar spine, and decreased sensation to light touch of the lumbar spine. There was back stiffness and weakness, as well as muscle spasm. There was also poor balance and generalized weakness. A clinic note dated 10/16/13 stated that the patient is with pain - approximately 90% is back pain, and only 10% occasionally is leg pain. Range of motion includes flexion (in the standing position) at 40 degrees bilaterally, normal 80. Sitting straight leg raises -90 right, -90 left, -90 normal. Lying straight leg raises +60 right, +60 left, -70 normal. The patient was diagnosed with right shoulder severe post traumatic arthrosis of the acromioclavicular joint symptomatic with downsloping acromion type 3 with impingement; lumbar degenerative disc disease and degenerative joint disease; status post decompression at L4-5 and L5-S1, with three surgeries; prior lumbar infection, postoperative; chronic back pain, moderate; anxiety and depression; insomnia; GERD; and sexual dysfunction

IMR ISSUES, DECISIONS AND RATIONALES

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

request for a lumbar epidural steroid injection at L4-L5 between 10/30/13 and 12/29/13:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: As per the California MTUS, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing to meet the criteria for epidural steroid injections (ESIs). On 10/16/13, the patient was documented as having mostly back pain and did not indicate any signs of radiculopathy. On 5/18/13 an EMG/NCV study was performed; results were normal. Based on the lack of documented findings of radiculopathy, the patient would not qualify for an ESI. Further, the purpose of ESI is to reduce pain and inflammation and restoring range of motion, thereby facilitating progress in more active treatment programs, and avoiding surgery; this treatment alone offers no significant long-term functional benefit. There is no documentation of the patient undergoing an active treatment program. The request is non-certified