

Case Number:	CM13-0061271		
Date Assigned:	12/30/2013	Date of Injury:	08/06/2012
Decision Date:	05/12/2014	UR Denial Date:	11/24/2013
Priority:	Standard	Application Received:	12/04/2013

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 Occupational 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 20 year old male who was injured on 11/20/2013. The mechanism of injury is unknown. Prior treatment history has included current medications to be Naproxen 550 mg bid and Gabapentin 600 mg. The patient underwent fluoroscopically guided contrast enhanced right L5 transforaminal epidural steroid and anesthetic injection with epidurogram and fluoroscopically guided contrast enhanced right S1 transforaminal epidural steroid and anesthetic injection with epidurogram on 10/10/2013. Diagnostic studies reviewed include on 12/17/2012 EMG/NCV revealed normal electrodiagnostic study of the lower limbs. No electrodiagnostic evidence of lumbosacral radiculopathy or neuropathy. MRI of the lumbar spine w/o contrast dated 10/17/2013 revealed L5-S1 2-3 mm posterior disc bulge or protrusion is present which indents the epidural fat and abuts descending nerve roots within the lateral recesses bilaterally, left more than right. Central canal and neural foramina are relatively patent. Chronic appearing mild degenerative disc disease at L3-4 with anterior disc osteophyte in the superior anterior corner of L4. Broad mild posterior disc protrusion at L5-S1 as described above. Findings actually appear slightly worse on the left than on the right, from an imaging standpoint, despite the fact that the patient's symptoms are on the right. Physiatry follow up note dated 09/10/2013 documented the patient reports he had complete relief of the right leg pain for 3 days, then the posterior thigh pain and leg weakness returned. He says that the right buttock pain is gone. But he still has pain in the right lower back and posterior thigh and calf pain. He describes symptoms of right lower back pain in the right lower back and posterior thigh and calf pain. He describes symptoms of right lower back pain with radiation to the posterior thigh and calf. In terms of severity, he rates the pain as 6/10. These symptoms have been present since the injury and originally occurred in the context of L5-S1 disc herniation. He reports that the symptoms are constant and made worse by standing and sitting for long periods of time and alleviated by

Naproxen and gabapentin. The pain is associated with pain and numbness radiating down the right leg. Objective findings reveal gait appears normal and station is normal. No obvious pelvic obliquity noted. AROM: he has decreased lumbar forward flexion, extension, lateral side bending. Oblique side bending did not reproduce pain. There was good reversal of lumbar lordosis. Tender lumbar paraspinal muscles on the right. Physiatry follow up note dated 11/11/2013 documented the patient with complaints of left lower back pain with radiation down the posterior lateral left leg. He now states that the right L5-S1 transforaminal epidural steroid injections relieved his right lower back and radicular symptoms. He continues to have left lower back pain that radiates on the left posterolateral left thigh and calf. He has noticed that it is worse with standing and he has noticed a little bit of weakness. He continues to take Naproxen and gabapentin but that does not relieve the pain. Objective findings include light touch sensation was decreased in the left L5 and S1 dermatome. Straight leg raise was positive on the left. A 5/5 strength of the left leg was noticed. Plan: 1. The patient will undergo left L5 transforaminal epidural steroid and anesthetic injection with epidurogram. 2. Fluoroscopic guided contrast-enhanced left S1 transforaminal epidural steroid anesthetic injection with epidurogram. QME visit noted dated 11/13/2013 documented the patient with complaints of pain in low back. He continues to have pain in his lower back, this is more or less in the mid portion of the lower back below belt level. He cannot lift over 20 pounds. There is occasional left leg pain, he has difficulty sleeping at night and is stiff in the morning. He takes Naprosyn and gabapentin. Objective findings on exam revealed a well nourished and developed young male in no distress. He is 5'5 tall and weighs 140 pounds and is right handed. The back is elevated and he can bend so that the fingertips touch the toes. Right and left lateral bending was to 45 degrees, extension of the back 10 degrees. Straight leg raising 80 degrees bilaterally. Leg lengths are right 36, left 36, thigh right 18, left 18, calves right 13, left 13. Reflexes physiological and no sensory deficit involving the legs and no obvious muscle weakness. Objectively there is very little to see other than the restriction of the extension of the back and no sign of nerve root pressure or irritation at the present time. Progress note dated 11/20/2013 documented the patient with complaints of pain located in the back. He describes it as ache to sharp. He considers it to be medium. It has been about six months since the onset of pain. He says that it seems to be constant. He has noticed that it is made worse by bending. It is accompanied by pain left and right leg. He feels stable. His pain level is 4/10, 60% of normal. Examination of the lumbar spine reveals an abrasion is not present. Bruising is not present. Erythema is not present nor is an open wound. Pain on motion is present with extension > flexion. Pain to palpation is present in lower lumbar. A rash is not present. There are no erythema, ecchymosis, scars, masses, swelling or deformities in the back. Active flexion measures 90 degrees, extension 30 degrees, right lateral side bending 45 degrees and left lateral side bending 45 degrees. Active right lateral rotation measures 45 degrees, passive left lateral rotation 30 degrees. He is standing and walking can be performed. Movement of the back causes pain. Range of motion is normal. A surgical scar is not present. Scoliosis is not present. Sensation in the lower extremities is normal. SLR is negative bilaterally. Squatting can be performed. Tenderness is present in the midline. Toes standing and walking can be performed. Range of motion is limited to flexion to mid tibia and extend 20-25 degrees. Normal gait. Lasegues's straight leg raise is negative. 2+ DTRs and 5/5 motor strength in lower extremities. Negative EHL weakness. 2+ Pedal pulses. Left knee reflex is 2+/4. Right ankle reflex 2+/4. Light touch sensation is normal. Gait is normal. Motor strength is 5/5 bilaterally symmetrical. He is able to move with slight difficulty. Left knee reflex is 2+. Left ankle reflex is 2+. Right knee reflex is 2+ and right ankle reflex 2+. Diagnosis: 1. Sprain, lumbar spine 2. Lumbar radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRANSFORAMINAL EPIDURAL STEROID INJECTION AT LEFT L5-S1: 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 Section.

Decision rationale: This is a request for left L5-SI epidural steroid injection for a young male with chronic low back and radicular pain. The patient underwent right L5-S1 ESI on 10/10/13 with relief initially but unclear lasting benefit or reduction in pain medication use. Thereafter, symptoms began to involve the left lower extremity, and left L5-S1 ESI was requested. However, the patient's symptoms are not consistent across medical reports. QME report 11/13/14 notes no signs of radiculopathy on examination. EMG 12/7/12 was normal. MRI 10/17/13 does not demonstrate nerve impingement. Radiculopathy is not clearly established. The request for L5-S1 ESI is non-certified.