

<b>Case Number:</b>	CM13-0062311		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/30/1998
<b>Decision Date:</b>	05/09/2014	<b>UR Denial Date:</b>	11/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/06/2013

### 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 Neuromusculoskeletal Medicine, and is licensed to practice in Arizona. 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:

This is a 63-year-old female who sustained a work related injury on Dec 17, 1995 in which a 20 pound solid metal sign fell on top of the patient's head. The patient re-injured the spine in a slip and fall on July 21, 1996. Since that time, she has had continuous neck and back pain. She subsequently underwent fusion of her thoracic spine from T5 to T11 to correct a significant kyphosis. At some point later she developed paraplegia that may have been resultant of a pedicle screw that eroded through the bone and was sitting in the middle of spinal canal that may have been the cause of her spasticity of the lumbar and lower extremity; predominately the right side. She has undergone numerous spinal surgeries. She also has incomplete paraplegia of her lower extremities. An MRI dated Aug 3, 2012 demonstrates a 4.1mm anterolisthesis of C6-7 with evidence of anterior instrumented fusion at C3-4 and C4-5 and a posterior instrumented fusion from T5-S1 with an 80% vertebral body collapses with a 4.5mm disc herniation at T9-T10; last, there is severe kyphosis at L2-3 within the area of the fusion. The patient underwent re-fusion of her thoracic spine from T3 to T11 as revision of original fusion and to perform a laminectomy of T11 and repair a burst fracture at T11-12 on Feb 4th, 2013. One week later she underwent both posterior and anterior fusion in the lumbar region because of lumbar intervertebral disc disease with radiculopathy at the L5-S1 level. She experienced post-surgical complications of peritonitis secondary to a perforated viscus that ultimately required a bowel resection and anastomosis during an abdominal surgery that later fossilized, requiring two further operative cleanouts with the wound remaining open until secondary healing could occur. During her in-patient course from May 28 to June 12, 2013, she experienced severe spasticity of her lumbar region and legs requiring intrathecal Baclofen for treatment and underwent a lumbar laminectomy. She later developed an enterocutaneous fistula requiring re-hospitalization on July 1, 2013 in which she underwent additional abdominal surgery to repair her fistula and an incidental incisional hernia.

Her lumbar and predominately right lower extremity spasticity returned despite continuous baclofen intrathecal treatment to point of contracture of the right leg by half the distance of full extension with difficulty straightening because of pain and the degree of severe spasticity. On her most recent primary treating physicians follow up report dated 10/03/2013, she had pain 8 out of 10 in her mid to lower back. On exam, she had brisk reflexes of both lower extremities with positive ankle clonus bilaterally. She has muscle atrophy of her right lower extremity with significant tone noted in both lower extremities, but right greater than left. For pain management, the patient is on OxyContin 40mg and Dilaudid 4mg with plan to transition from the Dilaudid to Norco. She continues intrathecal Baclofen at 150 mcg/mL, with Dilaudid 20mg per mL at an infusion rate of 3.5 to 4mg / day. The patient underwent an epidural steroid injection at the L5-S1 level on March 19, 2009 that helped to alleviate her pain with 'notable improvement in mobility and activity tolerance'.

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

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

#### **THERAPEUTIC FLUOROSCOPICALLY GUIDED TRANSFORAMINAL EPIDURAL STEROID INJECTION (ESI) AT LEVEL S1 BILATERALLY: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain that "must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing" with the procedure performed under fluoroscopy for guidance. Repeated ESI treatment "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". The MTUS Chronic Pain Guidelines are specific as to what must be demonstrated in order to obtain an ESI. Although the patient complains of radicular symptoms and there is documentation of such, there is neither electrodiagnostic testing nor imaging studies that corroborate with her complaint. Her previous ESI was prior to L5-S1 fusion, which significantly changes the environment and conditions of the sacroiliac joint. Based upon an extensive review of the documentation provided for review and the MTUS Chronic Pain Guidelines' criteria for ESI, the request is not medically necessary and appropriate.