Case Number:	CM13-0062974		
Date Assigned:	04/02/2014	**Date of Injury:**	08/14/2013
Decision Date:	05/26/2014	**UR Denial Date:**	11/11/2013
Priority:	Standard	**Application Received:**	12/09/2013

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 49 year old who was injured on 08/14/2013. The patient used to work at a school cafeteria. The low back pain has been off and on in character. She has significant back pain and radiculopathic pain in her left lower extremity. Diagnostic studies reviewed include MRI of the lumbar spine dated 09/05/2013 revealing the following: 1. T12-L1: There is no significant disc desiccation. There is no significant loss of disk height. There is no significant disc bulge or herniation or facet arthropathy. The spinal canal and neural foramina remain adequate. 2. L1-L2: There is no significant disc desiccation. There is no significant loss of disk height. 1-2 mm left lateral/intraformainal disc bulge is present. There is no significant facet arthropathy. The spinal canal and neural foramina remain adequate. 3. L2-L3: There is mild disc desiccation. There is no significant loss of disc height. 2-3 mm central left paracentral broad based protruding disc bulge is present. In addition tosomewhat congenitally short pedicles contributes to mild spinal canal stenosis. There is no significant facet arthropathy. 4. L3-L4: There is no significant disc desiccation. There is no significant loss of disc height. There is no significant disc bulge or herniation. Mild to moderate facet arthropathy and ligamentum flavum hypertrophy contribute to moderate spinal cana/l stenosis. 5. L4-L5: There is disc desiccation. There is no significant loss of disc height. 3-4 mm disc bulge in addition to somewhat congenitally short pedicles and mild to moderate facet hypertrophy contribute to moderate spinal canal stenosis. 6. L5-S1: There is disc desiccation. There is no significant loss of disc height. 3-4 mm disc bulge with moderate facet arthropathy and ligamentum flavum hypertrophy in addition to somewhat congenitally short pedicles contributes to mild to left foraminal stenosis, mild to moderate spinal canal stenosis and mild to moderate right foraminal stenosis. PR-2 dated 08/28/2013 documented the patient to state, "I wanted my work restriction to be changed. I feel I can do my regular work. My back is feeling much better than when I first came in on Monday. I went to physical therapy,

I had my evaluation, and my back feels much better. Pain is only about 2-3/10 now. I just wanted to make sure everything was okay. I was worried; I wanted to get an MRI scan of my back". Objective findings on exam reveal the lumbosacral spine with no edema or erythema or ecchymosis formation. Full range of motion of the lumbar spine is performed. Flexion 90 degrees, extension 10 degrees, rotation to the right 40 degrees, rotation to the left 40 degrees, lateral tilt bend to the right 20 degrees, lateral tilt bend to the left 20 degrees with pain though. Deep tendon reflexes are 1+ bilaterally, both patella and Achilles. Straight leg raise is negative bilaterally. The patient ambulates with a non-antalgic gait. There is tenderness of the left lower paralumbar muscle region. Treatment Plan: 1. Continue physical therapy as scheduled. 2. Continue medication as directed. 3. The patient was advised at this time. Since she has improvement based on her physical findings. PR-2 dated 09/09/2013 documented the patient complains of lower back pain radiating to her left lower extremity. No numbness in her extremities. Objective exam reveals exam of the back, she still has tenderness along L4, L5 and S1, mostly on left side and left gluteal area. Forward flexion is about 30-40 degrees and right and left lateral rotation and bending is about 30-35 degrees. Extension is about 10 to 15 degrees. Heel-toe is negative. SLR is negative. No neurovascular or sensory deficit.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL MULTI LEVEL LUMBAR SELECTIVE EPIDURAL WITH FLUOROSCOPY AND ANESTHESIA: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chapter Criteria For The Use Of Epidural Steroid Injections.

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

Decision rationale: "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below.
Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three."
Criteria for the use of Epidural steroid injections:
Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.
2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
3) Injections should be performed using fluoroscopy (live x-ray) for guidance.
4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.
5) No more than two nerve root levels should be injected using transforaminal blocks.
6) No more than one interlaminar level should be injected at one session.
7) 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, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)
8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections."

Clinic notes from [redacted] dated 10-4-2013 detail an MRI with disc bulges and a PE with an assessment of left radiculopathy. However, the patient clearly reports getting better and desire to RTW. It is my opinion that this patient does not meet the criterion #2 above. Therefore, this is not medically necessary.