MAXIMUS Federal Services

Case Number:	CM14-0011687		
Date Assigned:	02/21/2014	Date of Injury:	03/26/2013
Decision Date:	06/27/2014	UR Denial Date:	01/10/2014
Priority:	Standard	Application Received:	01/29/2014

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 and 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 61-year-old female who was injured on 03/26/2013 when her ankle buckled and she fell backwards, landing on her buttocks. X-rays of the lumbar spine dated 08/16/2013 reveals 1) Discogenic spondylosis from T12 through L5, most severe at L2/L3; 2) Facet arthrosis of the lumbar spine; atherosclerotic calcific plaquing in the abdominal aorta extending into the splenic and iliac and femoral arteries. There is no gross evidence of ectasia. 3) Postural comments and biomechanical alterations noted and described above. A MRI of the lumbar spine dated 06/07/2013 revealed a 4 mm board-based disc bulge at L4-L5 without significant central canal narrowing and with mild bilateral neural foraminal narrowing. There is a 3 mm board-based disc bulge at L5-S1 without significant central canal narrowing and with mild bilateral neural foraminal narrowing. 3) There are 2 mm board-based disc bulges at L2-L3 and L3-L4 without significant central canal or neural foraminal narrowing and 4) Loss of the normal lumbar lordosis that may be secondary to patient positioning or indicate muscle spasms. A MRI of the right ankle 06/07/2013 demonstrates an element of posterior tibial tendon tenosynovitis and perhaps type I posterior tibial tendon tear. The functional assessment test was performed revealing low back pain and disability index score of 41 on 08/16/2013; a score of 31 on 10/04/2013; and a score of 28 on 11/20/2013. She now can exercise on the bike, walk longer, and stand longer than initially. The patient is diagnosed with sprain/strain ankle, internal derangement of ankle, lumbar IVD with facet syndrome by MRI, and lumbar sprain/strain. The treatment and plan include physiotherapy as the patient's condition has improved. The primary treating progress report dated 12/27/2013 states the patient has complaints of ankle pain, lower back pain, fatigue, stress and depression. She takes over the counter analgesics to control the pain. She uses Aleve, hot and cold packs, topical medication and patches. Objective findings on examination of the cervical spine revealed foraminal compression was positive on extension

which is now negative. Distraction test was positive. The dorsal-lumbar spine range of motion exhibits extension to 20/30 with pain; bilateral rotation to 25/30. Kemp's test was positive bilaterally without radiation, which is now negative. Trendelenburg's on the right was positive but is now negative. Cough test was positive thoracolumbar is now negative. Palpation of the spine elicits a pain response with digital pressure on the L4, L5, and sacroiliac joints. Ankle exam reveals a +2 edema on the right lateral ankle. There is pain on palpation over the lateral compartment. There is crepitus on range of motion. Ankle range of motion dorsiflexion on the right is 5/15. Palmar flexion on the right 30/50, eversion on the right is 10/20 and inversion to 30/35. The prior UR dated 01/10/2014 states the request for lumbar epidural steroid injection at L4 and L5 were non-certified as the procedure is not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR EPIDURAL STEROID INJECTION AT L4 AND L5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Epidural Steroid Inject.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESI) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar and Thoracic, Epidural Steroid Injections

Decision rationale: The CA MTUS and ODG Guidelines recommend lumbar epidural steroid injections (ESI) as a treatment to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction in medication use, and avoiding surgery. The guidelines state that the indications for the use of ESIs include: documentation of the presence of radiculopathy by physical examination and corroborated by imaging and/or electrodiagnostic testing, failure to response to conservative treatment (exercises, NSAIDs, physical therapy), use of fluoroscopy, and no more than 2 injections. The medical records document no evidence of lumbar radiculopathy, either by physical examination or imaging/electrodiagnostic testing. Further, the documents show no documentation of failure to respond to more conservative treatments. Based on the MTUS and ODG guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary. The request is not medically necessary.