

Case Number:	CM14-0183998		
Date Assigned:	11/10/2014	Date of Injury:	04/11/2013
Decision Date:	12/18/2014	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/05/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 45-year-old woman who sustained a work-related injury April 11, 2013. Subsequently, she sustained chronic neck and low back pain. Her MRI of the lumbar spine obtained on April 11, 2013 showed evidence of a 5 mm to 6 mm disc bulge causing left foraminal narrowing and a very degenerative disc at L5-S1. MRI of the cervical spine obtained on August 6, 2013 showed strengthening of cervical lordosis, and moderate spondylosis, mild canal stenosis C5-6 with 3 mm broad-based disc bulge indenting anterior spinal cord resulting in mild canal stenosis. A NCS/EMG performed on March 13, 2014 documented acute left C6-7 radiculopathy and acute bilateral L5-S1 radiculopathy. Prior treatments included: ESI (first on October 2, 2014), with no significant improvement in pain in the lower back and legs; physical therapy, medications, and acupuncture treatments. According to the progress report dated October 20, 2014, the patient complained of constant moderate-to-severe lower back pain, spreading to the buttocks. Lower back pain was tingling, electrical sensation and burning, in the back of the legs, down to the 1-2 toes. She complained of weakness of the legs. The patient was unable to fall asleep or stay asleep due to pain and anxiety. She complained of migraine headaches occurring 2 times a month associated with aura and light sensitivity. She complained of left occipital, burning pain, increased with neck pain. She complained of decreased memory, concentration, attention, and forgetfulness. Cervical spine examination revealed paravertebral muscle tenderness on the left more than right and severe occipital notch tenderness on the left, slight on the right, hyperesthesia in the distribution of the left more than right occipital nerve. Shoulder examination revealed normal range of motion. Trigger points at the trapezius, supraspinatus, and infraspinatus, left greater than right. Positive Tinel's sign left cubital tunnel and Epicondyle tenderness on the left. Lumbar spine examination revealed severe paravertebral muscle tenderness bilaterally, left greater than right, sciatic notch tenderness, left greater than

right, straight leg raising sign positive on the left at 45 degrees. Range of motion: flexion 30 degrees, extension 8 degrees, lateral bending to the right 15 degrees and to the left 8 degrees. There was a decreased light touch and pinprick in the left L5-S1 distribution. Deep tendon reflexes were +2 upper extremities, +1 bilateral knees and right ankle, absent left ankle jerk. The patient was diagnosed with musculoligamentous sprain/strain of the lumbar spine with left L5-S1 radiculopathy, musculoligamentous sprain/strain of the cervical spine with radicular component to the left, post concussion syndrome with cognitive impairment, vestibular impairment, depression, anxiety, and sleep impairment, severe depression. The provider requested authorization for Diagnostic Transforaminal ESI (epidural steroid injection) bilateral L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic Transforaminal ESI bilateral L5-S1 (2nd of series of 2): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: According to MTUS guidelines, epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit, however there is no significant long term benefit or reduction for the need of surgery. Furthermore, the patient file does not document that the patient is candidate for surgery. She was treated with conservative therapy without full control of the patient pain. Documentation does not contain objective findings on exam to support the presence of radiculopathy: strength, sensation, and reflexes are noted to be intact. There is no documentation that the patient have a sustained pain relief from a previous use of steroid epidural injection. Furthermore, MTUS guidelines does not recommend epidural injections for back pain without radiculopathy. MTUS guidelines, recommended repeat epidural injection is considered only if there is at least 50% pain improvement after the first injection for at least 6 to 8 weeks. The patient did not fulfill criteria. Therefore, Diagnostic Transforaminal ESI bilateral L5-S1 is not medically necessary.