

<b>Case Number:</b>	CM14-0025860		
<b>Date Assigned:</b>	06/04/2014	<b>Date of Injury:</b>	08/26/2001
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	02/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/01/2014

### 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 49-year-old woman who sustained a work-related injury on August 26, 2001. Subsequently, she sustained chronic low back pain. An MRI of the lumbar spine without and with intravenous gadolinium was performed on November 10, 2011 in comparison with an MRI of the lumbar spine on January 27, 2010 and this revealed previous laminectomy and fusion involving L4-S1. No evidence of recurrent protrusion or significant lumbar spinal stenosis. X-rays of the lumbar spine were obtained on October 14, 2013 that demonstrated an instrumented anterior-posterior fusion at the L4-5 and L5-S1 levels. There appeared to be a solid arthrodesis at both of these levels, both anterior antibody/posterolateral. There were pedicle screws present posteriorly. There were bone dowels in an anti-kick-out plate at the L5-S1 level. Both levels appeared slightly arthrodesed. Of note, there was a mild right lumbar curve with apparent junctional left-sided breakdown left L3-4 on the lateral x-ray, the first disc space parallel with the floor was L2-3. Based on the medical report dated on October 14, 2013, the patient complained of pain in the right side of her lower back and buttocks that occasionally spreads down into the back and right thigh that felt like a cramp. She rated her current pain as an 8/10. She had a significant past surgical history of laminectomy in 1999 and lumbar fusion in 2000. Her medications included: Vicodin, Soma, and Trazodone. Examination revealed a positive sagittal balance or she was leaning slightly forward. Lumbar range of motion was flexion to 50 degrees, extension to 5 degrees, left lateral bending 29 degrees, and right lateral bending 26 degrees. She reported some right-sided numbness in an L5 dermatomal distribution, otherwise normal sensation. Motor strength to manual testing was 5/5. Straight leg raise testing increased some tightness in her back and buttocks, but did not seem to produce sciatica. On December 9, 2013, the patient underwent placement of a right L3-4 anterior epidural catheter under fluoroscopy, epidural myelography with interpretation and supervision, and lumbar epidural steroid injection

under fluoroscopy with interavenous sedation. On January 30, 2014, a follow-up report stated that the epidural steroid injection the patient received has helped with her condition and the trigger point injections given to her in the office appeared to help control symptoms. Examination revealed tenderness to palpation noted about the left side of the lumbar paraspinal musculature. Active voluntary range of motion of the thoracolumbar spine was severely limited. The patient was able to forward flex about 50 degrees; however, extension was less than 5 degrees before stopping to complain of pain. Left and right lateral bending was also about 5 to 10 degrees before stopping to complain of pain. The straight leg raising test was felt to be negative at 70 degrees in the sitting as well as the lying position. The femoral stretch test was negative. Motor examination was felt to be normal in all major muscle groups of the lower extremities. Sensory examination was normal to light touch. The provider request authorization for repeat lumbar spine EPIDURAL STEROID INJECTION.

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

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

**REPEAT LUMBAR SPINE EPIDURAL STEROID INJECTION WITH FLUROSCOPY AND EPIDUROGRAPHY, UNKNOWN USE OF SEDATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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. He was treated with conservative therapy without full control of the patient pain. However, there is no documentation of clinical, radiological and electrodiagnostic evidence that support the diagnosis of lumbar radiculopathy. There is no objective documentation from a previous use of epidural injection. MTUS guidelines does not recommend epidural injections for back pain without radiculopathy (309). Therefore, REPEAT LUMBAR SPINE EPIDURAL STEROID INJECTION WITH FLUROSCOPY AND EPIDUROGRAPHY, UNKNOWN USE OF SEDATION is not medically necessary.