

<b>Case Number:</b>	CM14-0026065		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	02/06/2003
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	02/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2014

### 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 and is licensed to practice in California and Washington. 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 injured worker is a 55-year-old female who reported a blow to the left knee on 02/06/2003. She had reported a previous industrial injury in 1998 at which time she reported hurting her lower back via heavy lifting. On 06/02/2014, her chief complaint was her lower back pain, which she rated at between 6-10/10 in severity. She complained of bilateral buttock and leg pain greater on the left side than on the right. The pain radiated down her legs to the posterior thighs and down to her feet. Her symptoms were exacerbated with household activities, bending, flexion, sexual activities, standing more than 15 minutes, walking more than 15 minutes, and sitting more than 30 minutes. Her symptoms were relieved by lying down, application of ice, acupuncture, medications, and epidural steroid injections. She ambulated with the aid of a seated walker. She described her pain as aching and stabbing with paresthesias over the entire plantar surface of the right foot. She had 60% sensation of the left L3 dermatome, 40% to 50% sensation of the right L3 dermatome, 60% sensation of the L4 dermatome, 70% sensation of the left L5 dermatome, 40% to 50% sensation of the right L5 dermatome, 70% sensation of the left S1 dermatome, and 40% to 50% sensation of the right S1 dermatome. Motor strength testing revealed breakaway weakness diffusely predominant in the left lower extremity. She had lower back pain during the supine right leg sciatic tension testing and left popliteal pain with left leg supine sciatic tension testing, which led to eventual lower back pain. She was tender to palpation bilaterally at the L4-5 level and also at the lower thoracic area. Her diagnoses included multilevel lumbar stenosis, worse at L3-4, L2-3 and L1-2, multilevel lumbar degenerative disc disease, status post L4-5 fusion with instrumentation and hemilaminectomy on the left, status post hardware removal at L4-5, status post dorsal column stimulator implant revision and removal, chronic pain syndrome, underlying anxiety and depression syndrome, status post multiple left knee surgeries, status post multiple right shoulder surgeries, status post bilateral carpal tunnel

release, and status post left foot bone spur excision. Her medications included Lexapro 20 mg, Morphine Sulfate ER 60 mg, Lidoderm 5% patch, Voltaren 1% gel, Protonix 20 mg, Norco 10/325 mg, Lisinopril 10 mg, Metoclopramide 10 mg, Estrogen-Methyltestosterone tablets 1.25/2.5 mg, and Flexeril 5 mg. On 10/31/2013, she had a nerve conduction study, which revealed evidence of segmental demyelination of the common peroneal nerve at the knee suggestive of right common peroneal neuropathy without axonal loss. There was no evidence of right lower extremity radiculopathy, plexopathy, or other peripheral neuropathy. There was no evidence of a radiculopathy on the left lower extremity with the specific myotomes tested and there was no evidence of plexopathy or peripheral neuropathy in the left lower extremity. A lumbar MRI on 01/07/2014 revealed mild canal narrowing and moderate right neural foraminal narrowing with contact of the exiting right L1 nerve root, which had worsened since the prior MRI in 2004. The rationale for the requested procedure dated 03/06/2014 referring to the above noted MRI, stated that the MRI did correlate with her symptoms of right sided groin pain. She had not had that level (L1) injected in the past. The author of the report further stated that they believed that the injured worker required a lumbar epidural steroid injection at L1-2 on the right to see if this will be helpful for her. The report further stated that they wanted to try to avoid surgery with the injection. There was no request for authorization with the submitted documents.

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

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

**ONE RIGHT I1-I2 TRANSFORAMINAL LUMBAR EPIDURAL STEROID INJECTION, LUMBAR MYELOGRAPHY, LUMBAR EPIDUROGRAM, IV SEDATION, FLUOROSCOPIC GUIDANCE, CONTRAST DYE: 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 (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic, Myelography.

**Decision rationale:** The request for one right L1-L2 transforaminal lumbar epidural steroid injection, lumbar myelography, lumbar epidurogram, IV sedation, fluoroscopic guidance, contrast dye is not medically necessary. The California MTUS Guidelines recommend epidural steroid injections as an option for treatment of radicular pain. Epidural steroid injections can offer short-term pain relief and their use should be in conjunction with other rehab efforts, including a home exercise program. Among the criteria for the use of epidural steroid injections are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing and the condition must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, and muscle relaxants). Per The Official Disability Guidelines, myelography is not recommended except in certain conditions, including demonstration of the site of cerebral fluid leak, surgical planning, radiation therapy planning, diagnostic evaluation of spinal or basal cisternal disease, poor correlation of physical findings with MRI studies or the use of the MRI is precluded because of claustrophobia, technical issues, safety reasons, or surgical hardware. This injured worker does not fall into any

of these categories. This injured worker has undergone an epidural steroid injection at level L1 and L2 on 03/18/2014. In a 03/27/2014 progress note, 9 days after the epidural steroid injection, she reported that she was continuing to have radicular pain radiating down both thighs to the calves from her lumbar spine. Since there was no request for authorization found which was dated after the initial epidural steroid injection on 03/18/2014, and the current request does not state that it is a retrospective request, the response to the first epidural steroid injection was minimal, and there is no rationale for a second epidural steroid injection at levels L1-2. Additionally, since lumbar myelography is not recommended by the Official Disability Guidelines, the rest of the request likewise is not recommended. Therefore, the request for one right L1-L2 transforaminal lumbar epidural steroid injection, lumbar myelography, lumbar epidurogram, IV sedation, fluoroscopic guidance, contrast dye is not medically necessary.