

Case Number:	CM14-0103663		
Date Assigned:	07/30/2014	Date of Injury:	05/19/1984
Decision Date:	02/28/2015	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/05/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Maryland, District of Columbia
 Certification(s)/Specialty: Internal Medicine

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 employee was a 74 year old male who sustained an industrial injury on 05/19/1984. He had a history of posterior lumbar fusion from L4 to S1 and subsequent posterior fusion L3-4 with interbody fusion. His prior treatment included rest, activity modification, oral medications and physical therapy. X-ray of the lumbar spine from 02/19/14 showed posterior instrumentation with fusion L3-L4 as well as interbody device. Posterior tension band wiring is noted from L4 to S1. The L4 and S1 levels appear fused and moderate degenerative changes at L1-2 and L2-3 with mild retrolisthesis of L2 on 3. The visit note from 04/03/14 was reviewed. His subjective complaints included low back pain radiating down both legs at 2/10. His CT scan of the lumbar spine was reviewed and noted to have fusion L3-S1 and the transitional level L1-3 collapsed with minimal retrolisthesis and trefoil changes, causing marked stenosis, centrally and laterally. He had kyphotic wide based short stride and decreased L5 and S1 dermatomal sensation and in the tips of all toes. The plan of care included transforaminal versus translaminar L2-3 lumbar epidural injections. EMG was denied. On 05/21/14 bilateral L2-L3 transforaminal epidural steroid injection was done. The progress note from 05/30/14 was reviewed. He reported that the injections improved his pain higher in the lumbar spine. But he had pain now in the lower lumbosacral junction with pain radiating across the belt line and down the left leg. He was noted to be using less of Norco and was trying to wean off of it. So to address the lower lumbar pain with radiculopathy symptoms, a request was sent for L5-S1 epidural injection. According to MTUS, Chronic Pain Medical Treatment guidelines, epidural steroid injections are recommended as an option for radicular pain in the setting of radiculopathy documented by

physical examination and corroborated by imaging and/or EDS, unresponsive to conservative treatment and no more than two nerve root levels to be injected using transforaminal blocks and no more than one interlaminar level at one session. 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. The employee had lumbar radiculopathy symptoms and signs. He noted improvement with previous lumbar ESI at a higher level. Now he had symptoms lower at the lumbosacral level and the provider recommended ESI at L5-S1. Hence the request for transforaminal L5-S1 epidural steroid injection is medically necessary and appropriate.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L5 and S1 Transforaminal Epidural Steroid Injection: Overturned

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

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

Decision rationale: The employee was a 74 year old male who sustained an industrial injury on 05/19/1984. He had a history of posterior lumbar fusion from L4 to S1 and subsequent posterior fusion L3-4 with interbody fusion. His prior treatment included rest, activity modification, oral medications and physical therapy. X-ray of the lumbar spine from 02/19/14 showed posterior instrumentation with fusion L3-L4 as well as interbody device. Posterior tension band wiring is noted from L4 to S1. The L4 and S1 levels appear fused and moderate degenerative changes at L1-2 and L2-3 with mild retrolisthesis of L2 on 3. The visit note from 04/03/14 was reviewed. His subjective complaints included low back pain radiating down both legs at 2/10. His CT scan of the lumbar spine was reviewed and noted to have fusion L3-S1 and the transitional level L1-3 collapsed with minimal retrolisthesis and trefoil changes, causing marked stenosis, centrally and laterally. He had kyphotic wide based short stride and decreased L5 and S1 dermatomal sensation and in the tips of all toes. The plan of care included transforaminal versus translaminar L2-3 lumbar epidural injections. EMG was denied. On 05/21/14 bilateral L2-L3 transforaminal epidural steroid injection was done. The progress note from 05/30/14 was reviewed. He reported that the injections improved his pain higher in the lumbar spine. But he had pain now in the lower lumbosacral junction with pain radiating across the belt line and down the left leg. He was noted to be using less of Norco and was trying to wean off of it. So to address the lower lumbar pain with radiculopathy symptoms, a request was sent for L5-S1 epidural injection. According to MTUS, Chronic Pain Medical Treatment guidelines, epidural steroid injections are recommended as an option for radicular pain in the setting of radiculopathy documented by physical examination and corroborated by imaging and/or EDS, unresponsive to conservative treatment and no more than two nerve root levels to be injected using transforaminal blocks and no more than one interlaminar level at one session. 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. The employee had lumbar radiculopathy symptoms and signs. He noted improvement with previous lumbar ESI at a higher level. Now he had symptoms lower at the lumbosacral level and the provider recommended ESI at L5-S1. Hence the request for transforaminal L5-S1 epidural steroid injection is medically necessary and appropriate.