

Case Number:	CM14-0143121		
Date Assigned:	09/10/2014	Date of Injury:	03/16/2012
Decision Date:	01/07/2015	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/04/2014

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 Internal Medicine and is licensed to practice in Maryland. 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 employee was a 36 year old female who sustained an industrial injury on 03/16/12 when she slipped, fell and rolled down the stairway. Her prior treatment included chiropractic treatment, NSAIDs, Flexeril, Tramadol, functional restoration program, Ultram, Diclofenac and physical therapy. Cervical spine MRI from 05/14/12 showed no central canal stenosis, C3-4 and C4-5 mild bilateral foraminal narrowing, C5-6 mild-moderate bilateral foraminal narrowing and C4-6 posterior annular bulge with no cord or nerve root compression. Lumbar spine MRI from 05/14/12 revealed mild to moderate facet arthropathy from L3-S1, no foraminal compromise detected, 1-2mm circumferential disc extrusion/bulge from L3-S1 without central canal stenosis or foraminal compromise. EMG from 1/28/13 showed cervical radiculopathy involving the bilateral C5/C6 nerve roots. The progress note from 08/05/14 was reviewed. The functional restoration program failed to provide pain relief. Her pertinent complaints were pain in mid back, lower back, with radiation to the right posterior thigh and leg, with tingling in the arms and feet, numbness in the feet and weakness in the legs. Pain was 8/10, aggravated by bending forward, reaching, kneeling, crawling, standing, sitting, walking, doing exercises, coughing or straining and pushing shopping cart and leaning forward. She can walk one block before having to stop because of her pain. Pertinent examination findings included full range of motion of lumbar spine, tenderness to palpation over the lumbar paraspinal muscles consistent with spasms, positive lumbar facet loading maneuver, right more than left, negative straight leg raising test and bilateral SI joint tenderness with positive Patrick's test. Sensory and motor examinations were normal. Pertinent diagnoses included lumbago and displacement of lumbar intervertebral disc without myelopathy. The request was for lumbar epidural steroid injection at L4-L5.

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-L5 level under fluoroscopic guidance QTY: 1.00:
Upheld

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

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

Decision rationale: The employee was a 36 year old female who sustained an industrial injury on 03/16/12 when she slipped, fell and rolled down the stairway. Her prior treatment included chiropractic treatment, NSAIDs, Flexeril, Tramadol, functional restoration program, Ultram, Diclofenac and physical therapy. Cervical spine MRI from 05/14/12 showed no central canal stenosis, C3-4 and C4-5 mild bilateral foraminal narrowing, C5-6 mild-moderate bilateral foraminal narrowing and C4-6 posterior annular bulge with no cord or nerve root compression. Lumbar spine MRI from 05/14/12 revealed mild to moderate facet arthropathy from L3-S1, no foraminal compromise detected, 1-2mm circumferential disc extrusion/bulge from L3-S1 without central canal stenosis or foraminal compromise. EMG from 1/28/13 showed cervical radiculopathy involving the bilateral C5/C6 nerve roots. The progress note from 08/05/14 was reviewed. The functional restoration program failed to provide pain relief. Her pertinent complaints were pain in mid back, lower back, with radiation to the right posterior thigh and leg, with tingling in the arms and feet, numbness in the feet and weakness in the legs. Pain was 8/10, aggravated by bending forward, reaching, kneeling, crawling, standing, sitting, walking, doing exercises, coughing or straining and pushing shopping cart and leaning forward. She can walk one block before having to stop because of her pain. Pertinent examination findings included full range of motion of lumbar spine, tenderness to palpation over the lumbar paraspinal muscles consistent with spasms, positive lumbar facet loading maneuver, right more than left, negative straight leg raising test and bilateral SI joint tenderness with positive Patrick's test. Sensory and motor examinations were normal. Pertinent diagnoses included lumbago and displacement of lumbar intervertebral disc without myelopathy. The request was for lumbar epidural steroid injection at L4-L5. 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. The employee had low back pain and lower extremity pain. There was no radiculopathy signs like neurologic deficits in a dermatomal pattern, no MRI findings of nerve root compression or radiculopathy findings in lower extremity EMG. There were no lower extremity electrodiagnostic studies available with the medical records. Hence the request for epidural steroid injection at L4-5 root level is not medically necessary or appropriate.