

Case Number:	CM14-0188676		
Date Assigned:	11/19/2014	Date of Injury:	09/21/2012
Decision Date:	01/09/2015	UR Denial Date:	10/09/2014
Priority:	Standard	Application Received:	11/12/2014

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 66-year-old woman who sustained a work-related injury on September 21, 2012. Subsequently, the patient developed chronic low back and neck pain. MRI of the lumbar spine dated November 20, 2013 showed moderate upper lumbar spine dextroscoliosis and multilevel disc degeneration throughout the lumbar spine. There was severe left L1-2 foraminal encroachment with a 3 to 4 mm posterior disc protrusion at L1-2, most pronounced posterolaterally, and there was a potential for impingement on the exiting L1 nerve. There was moderate to severe left L2-3 foraminal encroachment with 4 mm lateralization of a 4 mm posterior disc protrusion. There was mild to moderate L1-2 spinal canal stenosis. There was moderate L3-4 spinal canal stenosis with a 3 to 4 mm broad based posterior disc protrusion, and there was also severe right and moderate left L3-4 facet joint arthropathy. There was severe right and moderate to severe left L4-5 facet joint arthropathy with a 3 mm degenerative anterolisthesis of L4 on L5. There was severe L4-5 spinal canal stenosis, and there was also moderate to severe right L4-5 foraminal encroachment with potential for impingement on the exiting right L4 nerve. Moderate to severe right L5-S1 foraminal encroachment was also identified with bilateral L5-S1` facet joint arthropathy and a 3 mm posterior disc protrusion, and moderate to severe L5-S1 spinal canal stenosis was also shown. The patient underwent intra-articular joint injections into the left shoulder and lumbar epidural steroid injection at L5-S1, on July 17, 2014, that provided greater than 50% relief for 7 weeks. According to a note dated September 12, 2014, the patient complained of constant neck pain with radiating pain into her left shoulder as well as her bilateral upper extremities. The patient rated her neck pain as a 5/10. The patient complained of low back pain with pain radiating into her bilateral lower extremities. She reported lower extremities burning and numbness. Examination of the cervical spine revealed pain with forward flexion to 30 degrees and crepitus with extension to 20 degrees. The patient had pain with

rotation to the left to 25 degrees. The patient had lateral flexion to the right to 5 degrees and to the left 15 degrees. The patient had palpable cervicothoracic muscle spasm with myofascial trigger points and twitch response with referral of pain. The patient had pain to palpation over the occipital ridge, which reproduces headaches. Examination of the lumbar spine revealed a painful range of motion with forward flexion to 50 degrees and extension to neutral. The patient had pain with left lateral flexion to 15 degrees and right lateral flexion to 10 degrees. The patient was unable to perform a toe walk on the right foot. The patient had palpable lumbosacral paraspinous muscle spasm with myofascial trigger point and twitch response with referral to pain. Reflexes were 2+ and symmetric with bilateral biceps, triceps, and brachioradialis jerks. Reflexes were 3+ and symmetric at the knees and 1+ and symmetric at the ankles. Motor strength noted 4/5 in the right triceps, otherwise 5/5 and symmetric in arm flexion, extension, and shoulder abduction. The patient had pain in the low back and buttocks with right hip flexion. Sensation was decreased in the bilateral upper extremities in the C7 distributions, and the patient complained of numbness and tingling in the bilateral lower extremities in the L1 distributions. Straight leg raise was positive on the right at 40 degrees and negative on the left at 50 degrees. The patient was diagnosed with lumbar herniated nucleus pulposus and lumbar radiculopathy, bilateral lower extremities right greater than left, cervicgia, status post fusion C4-7 in 2008, cervical radiculopathy, myospasm and myofascial trigger points, and depression secondary to pain. The provider requested authorization for bilateral lumbar epidural steroid injection, catheter directed (right greater than left) at L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Lumbar Epidural Steroid Injection, catheter directed (right greater than left) at L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

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

Decision rationale: According to MTUS ACOEM Practice 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. In addition, there is no evidence that the patient has been unresponsive to conservative treatments. Furthermore, there is no recent clinical and objective documentation of radiculopathy. MTUS guidelines do not recommend epidural injections for back pain without radiculopathy. Therefore, bilateral lumbar epidural steroid injection, catheter directed (right greater than left) at L5-S1 is not medically necessary.