

Case Number:	CM14-0195832		
Date Assigned:	12/03/2014	Date of Injury:	04/11/2006
Decision Date:	01/21/2015	UR Denial Date:	11/14/2014
Priority:	Standard	Application Received:	11/21/2014

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 California. 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 an injured worker with lumbar back complaints. Date of injury was 04-11-2006. The progress report dated May 28, 2014 documented that she recently received an epidural injection in the lumbar spine by about two weeks ago. Overall, since receiving the epidural, she states that she is about 60 to 70% better, and that most of her pain down her left side has diminished. She does continue with some pain about the right leg. However, overall, she has noticed a great deal of improvement. On physical examination, there is tenderness to palpation about the right side of the lumbar paraspinal musculature. Active voluntary range of motion of the thoracolumbar spine was limited. The patient was able to forward flex to approximately 45 degrees and extend to 10 degrees before experiencing low back pain. Lateral bending was limited to 15 degrees in either direction. The patient was able to heel-and-toe walk across the examining room without difficulty. There was no evidence of any limp or antalgic gait. 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. Quadriceps reflexes were 1-2+ and symmetrical. Achilles reflexes were 0-1+ and symmetrical. No pathologic reflexes were evident. The patient appears to have some relief from the epidural steroid injection. The progress report dated June 11, 2014 documented continued right lower back pain radiating into the buttocks. She did very well with her first left-sided epidural steroid injection, which significantly reduced her left-sided pain. She now has residual right lower back and buttock pain. Assessment was improvement with first left-sided epidural steroid injection. A second injection was requested. The right L4-L5 anterior epidural recess under fluoroscopy to help further reduce her pain medications will be targeted. The progress report dated July 11, 2014 documented that the patient still notices an improvement following her epidural steroid

injection. She continues to have low back pain with radicular symptoms into the left leg. She was provided with an injection into the right greater trochanteric bursa under ultrasound guidance. The patient noticed quite a bit of improvement with the first epidural steroid injection. The progress report dated August 20, 2014 documented that the patient has noticed the effects of the first epidural wearing off and she has noticed an increased amount of low back pain as well as pain that radiates down the back of her thighs. She also experiences tingling and spasm in her legs. She also states that the injection into the greater trochanteric bursa at her last visit also improved her symptoms. The chloroquine has been helping with her cramping of the lower extremities. She received a tremendous relief from the first injection; however, these effects are beginning to wear off at this time and a second injection was requested. The progress report dated September 18, 2014 documented that the patient had back and bilateral radicular pain. The first epidural injection was of significant benefit allowing 50% reduction of her symptoms, but now she states her pain is beginning to return. The patient also exhibited significant right paralumbar trigger point, which was injected. The progress report dated October 15, 2014 documented that the patient states that the epidural steroid injection she had a few months ago appears to have worn off and because of this she has had an increased amount of low back pain as well as pain in both of her legs. A second epidural steroid injection was requested. The progress report dated November 5, 2014 documented that after receiving her first epidural steroid injection, she states she noticed a tremendous amount of pain relief and she rated her pain relief at a 70% to 80% overall improvement. A second epidural steroid injection was requested. The patient has noticed the effects of the first epidural wearing off. She states that her back pain is worsening at this time, and she continues to have pain that radiates into both of her legs. On physical examination, there is tenderness to palpation bilaterally about the lumbar paraspinal musculature. There is also spasm noted about the same area. Active voluntary range of motion of the thoracolumbar spine was limited. The patient was able to forward flex to approximately 45 degrees and extend to 10 degrees before experiencing low back pain. Lateral bending was limited to 15 degrees in either direction. The patient was able to heel-and-toe walk across the examining room without difficulty. There was no evidence of any limp or antalgic gait. The straight-leg-raising test is positive bilaterally for low back pain. Motor examination was felt to be normal in all major muscle groups of the lower extremities. Sensory examination was normal to light touch. Quadriceps reflexes were 1-2+ and symmetrical. Achilles reflexes were 0-1+ and symmetrical. No pathologic reflexes were evident. An x-ray was obtained of the lumbar spine noted degenerative disc disease at the L4-L5 level and L5-S1 level. No gross instability is noted on the x-rays. The first epidural steroid injection appeared to help with her symptoms. Epidural steroid injections into the lumbar spine in order to relieve the radicular pains into her legs were noted. A second epidural steroid injection into the lumbar spine was requested. She was provided with a trigger point injection bilaterally about the lumbar paraspinal musculature in areas that were noted to be of spasm and taut muscle fibers.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar ESI under Fluoroscopy Left L4-L5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 309, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses epidural steroid injections (ESIs). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints states that invasive techniques (e.g., local injections and facet-joint injections of cortisone and Lidocaine) are of questionable merit. Epidural steroid injections treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Chronic Pain Medical Treatment Guidelines (Page 46) states that epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The American Academy of Neurology concluded that epidural steroid injections do not affect impairment of function or the need for surgery and do not provide long-term pain relief. ESI treatment alone offers no significant long-term functional benefit. Criteria for the use of epidural steroid injections requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The progress report dated June 11, 2014 documented that the epidural steroid injection will target the right L4-L5 anterior epidural recess on the right. The requested procedure was for a lumbar left L4-L5 epidural injection on the left, which is inconsistent with respect to the laterality concerning left versus right. No electrodiagnostic testing was documented in the submitted medical records. No MRI magnetic resonance imaging was documented. No imaging studies or electrodiagnostic testing documenting nerve root compression was documented. Per MTUS criteria for the use of epidural steroid injections requires that radiculopathy must be corroborated by imaging studies or electrodiagnostic testing. Because MRI or electrodiagnostic corroboration was not documented, the request for lumbar L4-L5 epidural steroid injection ESI is not supported. Therefore, the request for Lumbar ESI under Fluoroscopy Left L4-L5 is not medically necessary.