

<b>Case Number:</b>	CM14-0206524		
<b>Date Assigned:</b>	12/18/2014	<b>Date of Injury:</b>	02/02/2009
<b>Decision Date:</b>	02/25/2015	<b>UR Denial Date:</b>	12/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2014

### 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 52 year old male who sustained a work place injury on 2/2/09. An MRI of cervical spine from 10/10/14 showed 1-2 mm broad based posterior disc bulge, mild bilateral facet degenerative changes, mild central canal and left neural foraminal narrowing. At C4-5, there was mild disc dessication, 2mm central disc protrusion and focus of annular fissure with mild spinal stenosis and mild left neural foraminal narrowing. At C5-6, there was 1-2 mm broad based disc protrusion, slightly intending the anterior cord with mild left neural foraminal narrowing. An x-ray of the lumbar spine from 06/26/14 showed mild scoliosis of the lumbar spine noted with facet hypertrophy at L5-S1. The progress note from 10/27/14 was reviewed. His subjective complaints included left shoulder pain and low back pain. Pertinent positive findings included painful and limited range of motion of the left shoulder with limited and painful range of motion of the lumbar spine. His diagnoses included left lumbar radiculopathy with annular tear. The progress note from 12/18/14 was also reviewed. He had intermittent back pain. He continued to work light duty. Examination showed painful and limited range of motion of the left shoulder, especially in abduction and flexion. There was slightly limited range of motion of the lumbar spine and negative straight leg raising test. Reflexes were symmetrical. Impressions included left shoulder injury with partial thickness tear of the rotator cuff and left lumbar radiculopathy, associated with annular disc tear. Prior work up included x-ray lumbar myelogram in 2013 that was negative except for L5 pars defect. An EMG/NCV in 2012 failed to reveal any evidence of radiculopathy. He did have symptoms of left lower extremity radiculopathy.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Epidural steroid injection (ESI) with left sided medial branch block with no level:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection (ESI).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back disorders, Facet joint blocks and epidural steroid injections.

**Decision rationale:** The employee was a 52 year old male who sustained a work place injury on 2/2/09. An MRI of cervical spine from 10/10/14 showed 1-2 mm broad based posterior disc bulge, mild bilateral facet degenerative changes, mild central canal and left neural foraminal narrowing. At C4-5, there was mild disc dessication, 2mm central disc protrusion and focus of annular fissure with mild spinal stenosis and mild left neural foraminal narrowing. At C5-6, there was 1-2 mm broad based disc protrusion, slightly intending the anterior cord with mild left neural foraminal narrowing. An x-ray of the lumbar spine from 06/26/14 showed mild scoliosis of the lumbar spine noted with facet hypertrophy at L5-S1. The progress note from 10/27/14 was reviewed. His subjective complaints included left shoulder pain and low back pain. Pertinent positive findings included painful and limited range of motion of the left shoulder with limited and painful range of motion of the lumbar spine. His diagnoses included left lumbar radiculopathy with annular tear. The progress note from 12/18/14 was also reviewed. He had intermittent back pain. He continued to work light duty. Examination showed painful and limited range of motion of the left shoulder, especially in abduction and flexion. There was slightly limited range of motion of the lumbar spine and negative straight leg raising test. Reflexes were symmetrical. Impressions included left shoulder injury with partial thickness tear of the rotator cuff and left lumbar radiculopathy, associated with annular disc tear. Prior work up included x-ray lumbar myelogram in 2013 that was negative except for L5 pars defect. An EMG/NCV in 2012 failed to reveal any evidence of radiculopathy. He did have symptoms of left lower extremity radiculopathy. According to MTUS, Chronic Pain Medical Treatment guidelines and ODG, facet joint blocks are recommended in neck and low back pain that is non radicular, in the setting of failure to improve with conservative treatment. Facet joint pain is suggested by tenderness to palpation in the paravertebral region with normal sensory examination, absence of radicular findings and normal straight leg raising exam. Whereas, ESIs are recommended as an option for radicular pain in the setting of radiculopathy documented by physical examination and corroborated by imaging and/or EDS. The employee had both neck and low back pain. It is unclear why both the procedures are being requested and what levels are being requested. Also, included in the request are two diagnostic procedures which if done together might not give a clear answer as to the origin of the pain. The request is not medically necessary or appropriate as it is unclear which levels are being requested and if it is cervical or lumbar.