

Case Number:	CM14-0111612		
Date Assigned:	08/01/2014	Date of Injury:	04/20/2011
Decision Date:	10/10/2014	UR Denial Date:	06/19/2014
Priority:	Standard	Application Received:	07/17/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine, 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 a 29-year-old female with an injury date of 04/20/11. The 05/19/14 report by ■■■ states that the patient presents with pain rated 6.5/10 and stiffness in her lumbosacral spine with radiculopathy into her bilateral lower extremities. The treater notes the patient has been taken off work by her primary physician until 05/15/14 for mental illness and she will return to modified duty on release. Examination reveals tenderness to palpation over the bilateral L4-5 and L5-S1 paraspinal, sacroiliac joints and piriformii. Sensory examination reveals sensation is intact to pin prick and light touch in the bilateral lower extremities, except for decreased sensation in the right L4--5 and L5-S1. Deep tendon reflexes are 2+ and equivocal bilaterally. Cranial nerves II-XII are intact. The 03/06/14 report by ■■■ cites the following studies: EMG/NCS findings bilateral lower extremity 10/26/11: 1.Evidence of a moderate-to severe lumbosacral radiculopathy at the right and left L4-5 level 2. Decreased velocity of the left and right peroneal motor. MRI of the lumbar spine 06/24/11: 1. L4-5 annular bulging posterior, minimal, no significant central canal or neural foraminal narrowing. 2. L5-S1 disc protrusion 2-3 mm broad-based, right paracentral; annulus tear, small, posterior, minimally, narrowing the right neural foramina, patent central canal and left neural foramina. MRI of the lumbar spine December 2011: 1. L3-L4 disc protrusion, diffuse; annular tear, left, posterior; thecal sac effacement; facet joint hypertrophy, bilateral; ligamentum flavum, hypertrophic configuration; neuroforaminal stenosis, bilateral, slight 2.4 mm disc measurement in neutral 2. L4-L5 disc protrusion, diffuse; thecal sac, effacement; facet joint effusion and hypertrophy, bilateral; ligamentum flavum, hypertrophic configuration; neuroforaminal stenosis, bilateral more marked on left side; 2.4 mm disc measurement in neutral 3. L5-S1: disc protrusion focal; annular tear, central posterior; osteophytic complex, effacement of thecal sac; perineural cysts, small, bilateral S1 transiting

nerve roots; facet joint hypertrophy, bilateral; 1.7 mm disc measurement in neutral. The patient's diagnoses include one. Lumbar degenerative disc disease². Lumbar radiculopathy 3. Numbness and Tingling. The utilization review being challenged is dated 05/09/14. The rationale is that a prior ESI was noted to have failed. Regarding the Right S1 joint injection, the rationale is that the only finding on exam is tenderness, which is insufficient. Treatment reports were provided from 01/09/14 to 06/02/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Tffesis at L4-5, L5-S1 under Fluoroscopic Guidance: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46,47.

Decision rationale: The treater presents with pain rated 6.5/10 and stiffness in the "lumbosacral spine radiating to the bilateral extremities." The treater requests for TFESI are at L4-5, L5-S1 under fluoroscope guidance. A review of the 05/12/14 treatment report shows that the patient is noted to have had, "an epidural of her lumbar spine in the later part of 2011 which she reports did not offer her substantial relief." No follow up reports of this procedure were provided. MTUS pages 46 and 47 states that Epidural Steroid Injections are recommended as an option for the treatment of radicular pain with corroborative findings for radiculopathy. Criteria for use include, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." MTUS further states, "Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. " Examination reveals tenderness over the" bilateral L4-5 and L5-S1 paraspinal, sacroiliac joints and piriformii" with decreased sensation "in the right L4--5 and L5-S1." The 10/26/11 EMG/NCV states there is evidence lumbosacral radiculopathy at the right and left L4-5 level. The MRI of the lumbar spine of December 2011 reports L4-L5 disc protrusion and neuroforaminal stenosis, bilateral more marked on left side and L5-S1: disc protrusion focal. In this case, documentation shows tenderness, EMG/NCV evidence (bilateral), MRI evidence of disc protrusion, stenosis (bilateral) at L4-5, and tenderness and MRI evidence of protrusion at L5-S1. Examination is corroborated by MRI and/or electrodiagnostic studies. Therefore, an ESI would be indicated but the patient has tried an ESI in 2011 without any benefit. MRI and EMG are from 2011 for which an ESI has been tried. There is no new information to consider repeating the injection. Recommendation is for not medically necessary.

Right SI Joint Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis (Acute & Chronic)

Decision rationale: The treater presents with pain rated 6.5/10 and stiffness in the "lumbosacral spine radiating to the bilateral extremities." The treater requests for: Right SI joint injection. ODG guidelines state SI joint injections are recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy. The treaters note in the reports if since before 03/06/14 the patient has undergone a course of conservative therapy including medications, TENS, and heat and ice application and home exercise. No physical therapy was noted. No NSAIDs were noted as recommended in ODG; however, the patient is post-gastric bypass surgery, which has limited oral medications in the past. ODG further states that, "The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed)." "Diagnosis: Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction: Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillett's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; Thigh Thrust Test (POSH)." The reports provided do not document 3 positive exam findings as stated above. Furthermore, the treater appears to be concerned about the patient's radicular symptoms, which is not consistent with SI joint syndrome. Recommendation is for not medically necessary.