

Case Number:	CM14-0028061		
Date Assigned:	06/23/2014	Date of Injury:	05/30/2012
Decision Date:	09/17/2014	UR Denial Date:	02/06/2014
Priority:	Standard	Application Received:	03/05/2014

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 and Pain 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 injured worker is a 53-year-old female who reported an injury on 05/30/2012. The mechanism of injury was noted as a slip and fall. The injured worker's diagnoses included knee pain and low back pain with multiple ligament strain and trigger points, lumbar muscle strain, spasm and bilateral L4-5 radiculopathy, and multiple trigger points in the lumbar spine. Other therapies included left L4 through S5, left L5-S1 transforaminal epidural steroid injection, trigger point injections on 01/15/2014 and 02/12/2014, physical therapy for the neck, low back and knee, acupuncture, and chiropractic treatments. Diagnostic studies included MRI of the lumbar spine without contrast on 05/09/2013; unofficial results noted 2 to 3 mm circumferential disc bulge; there was mild bilateral foraminal narrowing; there was mild central canal stenosis; there was prominent bilateral facet joint hypertrophy with ligamentum flavum redundancy; MRI of the left knee without contrast on 11/21/2012; unofficial results noted no evidence of internal derangement within the left knee and mild subchondral cystic changes along the posterior superior medial femoral condyle with minimal adjacent cartilage irregularity without focal high grade defect. Otherwise, the cartilage of the knee is intact. Surgical history was not provided within the medical records. It was noted on the progress report dated 01/15/2014 the injured worker complained of low back pain that was described as dull and aching in nature and reported radiation into the lower extremities with numbness, tingling and weakness into the lower extremities, left side worse than right, but bilaterally more consistent in nature. The injured worker reported the first epidural provided 40 percent to 60 percent relief. The examination of the lumbosacral spine revealed 6 trigger points in the lumbar spine and range of motion was unrestricted. The range of motion evaluation revealed forward flexion 60/60, extension 25/25, left and right lateral flexion 25/25, and left and right lateral rotation 45/45. The documentation noted the injured worker had straight leg raising from the supine position was negative at 90

degrees bilaterally. The documentation noted sensation was intact to light touch, pinprick, and 2 point discrimination in all dermatomes in the bilateral lower extremities. The documentation noted that chiropractic treatments had exacerbated the symptoms. It was noted on the progress report dated 02/12/2014, the injured worker complained of continued knee pain, dull aching in nature. The injured worker reported burning in the knee with numbness and tingling and rest partially relieves the pain. The injured worker complained of low back pain that was constant in nature and the pain was increased with squat, kneel, lift, push/pull, standing/sitting, driving back and forth and medications. The physical examination of the lumbosacral spine revealed tenderness to palpation over the lumbar spine and 6 trigger points were noted. There was tenderness along the lumbar ligaments, L1-L5. Range of motion evaluation revealed forward flexion 20/60, extension 20/25, left and right lateral flexion 25/25, and left and right lateral rotation 45/45. The documentation noted straight leg raising from the supine position was negative at 90 degrees bilaterally. The examination noted the injured worker was able to fully squat without difficulty or pain. Medications were not provided within the medical records. The provider requested an L4-5 epidural steroid injection #2 bilaterally. The requested treatment plan was noted to help mitigate residual symptoms. The Request for Authorization form was not provided within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 epidural steroid injection #2 bilaterally: 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 Injections (ESIs) Page(s): 46.

Decision rationale: The request for L4-5 epidural steroid injection #2 bilaterally is not medically necessary. The injured worker has a history of chronic low back pain, has participated in physical therapy, and received a lumbar epidural steroid injection at L5-S1 on 10/18/2013. The California MTUS Guidelines state that the purpose of epidural steroid injections (ESIs) is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long term functional benefit. The criteria for the use of ESIs include radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Additional criteria includes that patients are initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). The guidelines state that repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks. The progress report dated 02/12/2014 noted the injured worker complained of low back pain. However, the documentation failed to indicate if the injured worker had or denied any radiating symptoms into the lower extremities. Additionally, the documentation failed to provide any significant objective functional deficits to warrant the procedure. The documentation also noted that straight leg raising was negative bilaterally. The

subjective complaints and objective findings are not consistent with radiculopathy. Additionally, the documentation submitted for review noted the injured worker reported 40% to 60% benefit from the previous epidural injection; however, there is a lack of documentation to indicate the length the benefit lasted and if there was associated reduction in medication use. There is also lack of documentation to indicate failure of recent conservative care to include medications and physical methods to provide symptomatic relief and improve functional capacity to warrant the procedure. Based on the above, the decision for L4-5 epidural steroid injection # bilaterally is not medically necessary.