

Case Number:	CM14-0215854		
Date Assigned:	01/05/2015	Date of Injury:	09/08/2012
Decision Date:	02/24/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	12/23/2014

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 47 year old female was a membership refund clerk when she sustained an injury on September 8, 2012. The mechanism of injury was a basket being pushed and hitting her tailbone. The diagnoses and results of the injury included lumbo-sacral-coccygeal strain/exacerbation of underlying chronic disc disease of the lumbar spine and back pain. Past treatment included diagnostic studies, activity modification, aquatic and physical therapy, independent exercise program, pain and non-steroidal anti-inflammatory medications, and two epidural steroid injections. On January 14, 2013, an MRI of the lumbar spine revealed degenerative disc changes at L3-L4, L4-L5, and L5-S1; disc bulges at L3-L4 and L4-L5, disc bulge with annular fissure at L5-S1, minimal retrolisthesis at L3-L4 and L4-L5, mild facet arthropathy at L3-L4, mild to moderate facet arthropathy and thickening of the ligamentum flavum at L4-L5, mild narrowing of the left lateral recess at L4-L5, minimal foraminal narrowing bilaterally at L3-L4, and mild to moderate left foraminal narrowing and mild right foraminal narrowing L4-L5 and L5-S1. There was no significant central canal narrowing at L3-L4, L4-L5, and L5-S1. On December 13, 2013, the injured worker underwent bilateral sacroiliac joint steroid injections performed for the treatment of bilateral sacroiliac joint arthropathy. The treating physician noted on September 3, 2014, the injured worker had been previously treated with three epidural injections, which helped resolve her pain. On November 4, 2014, electrodiagnostic studies were positive for mild left L4-L5 radiculopathy with subacute and chronic denervation. On November 20, 2014, the treating physician noted the injured worker complained of constant, severe lower back pain that radiated

into her left buttock and down her left leg; sharp, pinching left calf pain, and decreased spine mobility. The physical exam revealed slow rising from seated to standing position, level shoulders and pelvis without evidence of list, normal lumbar lordosis and thoracic kyphosis, normal gait, and able to toe and heel walk without observed deficits. The lumbar range of motion was noted to be mostly diminished, motor strength was normal, and there was decreased sensation of the left lateral calf. The bilateral patellar and Achilles' reflexes were normal. Bilateral Faber's were negative. The bilateral hip range of motion was normal, seated and supine straight leg raise were negative, and there was midline lumbosacral tenderness. There was no tenderness of the paralumbar muscles and bilateral sciatic notches. There were no spasms of the paraspinal muscles. Diagnoses were degenerative disc disease of L3-L4, L4-L5, and L5-S1; moderate left L4-L5 foraminal stenosis, and mild left L4-L5 radiculopathy with subacute and chronic denervation. Current medication was a non-steroidal antiinflammatory. The treating physician noted there had been essentially no improvement of the injured worker's symptoms since September 3, 2014 while under his care. The physician recommended an updated lumbar MRI, additional physical therapy, and a lumbar epidural steroid injection. Current work status is temporarily totally disabled. On December 17, 2014 Utilization Review non-certified a request for lumbar spine epidural steroid injection to the left L4-5 the requested on December 9, 2014. The lumbar spine epidural steroid injection was non-certified based on the lack of documentation of the injured worker quantified pain relief and/or reduction of pain medications, or increased functional improvement for at least six to eight weeks following the two epidural steroid injections the injured worker had received previously. The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Guidelines, Epidural steroid injections (ESIs) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural steroid injection for the lumbar spine; left L4-5: 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): 287-315, Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic (Acute & Chronic), Facet joint diagnostic blocks (injections), Epidural steroid injections (ESIs), therapeutic MD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections

Decision rationale: ACOEM Guidelines states invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. 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. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain. ODG and MD Guidelines agree that: One diagnostic facet joint injection may be

recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments (e.g., NSAIDs, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended. If after the initial block/blocks are given (see Diagnostic Phase above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. Per ODG, indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. The treating physician does not detail any functional improvement received by the patient after his last two epidural steroid injections. The physician also states that the patient has received no functional improvement since September, 2014. As such, the request for epidural steroid injection for the lumbar spine; left L4-5 is not medically necessary.