

Case Number:	CM15-0175623		
Date Assigned:	09/17/2015	Date of Injury:	01/06/2015
Decision Date:	10/26/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	09/08/2015

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: Texas, California

Certification(s)/Specialty: Family Practice

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 35 year old male, who sustained an industrial injury on January 6, 2015 and reported back pain causing him to fall to the floor followed by immediate pain in his low back, bilateral buttocks, bilateral hips, bilateral legs and bilateral knees. He also reported feeling dizzy, dazed, disoriented, weak, nervous and nauseated. The injured worker is diagnosed as having lumbar disc herniation without myelopathy, lumbar myalgia, lumbar myospasm, left sided lumbar neuritis-radiculitis and lumbar spinal stenosis. His work status is temporary partial disability. Currently, the injured worker complains of constant low back pain that radiates to his legs bilaterally (left leg radiculopathy is reported). There is weakness, numbness, giving way and locking noted and he rates his pain at 4-10 on 10. The pain prevents him from engaging in activities of daily living and is increased by bending (left and right), twisting (left and right), coughing, standing, sitting and walking. He also reports the pain is worse with bending forward, lifting and reaching. He reports frequent mid back pain described as a burning sensation that radiates to his neck and bilateral hips accompanied by weakness and numbness. He rates his pain at 4-10 on 10. The pain is exacerbated by bending forward, twisting (left and right), lifting and walking. Lastly he reports frequent bilateral buttock pain described as burning and cramping that radiates to his legs bilaterally and is associated with weakness and numbness. He rates the pain at 2-8 on 10 and is exacerbated by standing and walking. His pain scale is based on rest and activity. Physical examinations dated June 30, 2015-August 1, 2015 reveal there is "tenderness, guarding and spasm noted in the paravertebral regions and glutei bilaterally." Heel and toe walk causes pain, seated straight leg raise is positive bilaterally, flexion, extension and bilateral lateral

bending is 4 on 5 and pain and spasms restrict his range of motion. He is neurologically intact from L2-S1. "+SLR left, 4-5 MMT, 1+ patellar bilaterally, +TTP -5 in all planes." Treatment to date has included physical therapy (pain was 3 on 10 after 9 sessions, per note dated February 16, 2015), chiropractic care (no relief per note dated June 30, 2015), home exercise program, x-rays, CT scan and MRI in February 2015, physician note dated June 30, 2015 states "L5 shows transitional anatomy with a broad based fusion with a sacrum on the right, there is a resultant very thin, but normally hydrated lumbosacral disc." Developing degenerative disc desiccation and thinning at designated L3-L4 and L4-L5. At L2-L3, there is a low grade facet joint arthrosis without stenosis. At L3-L4 there is a broad based disc bulge with a central disc protrusion and overall mild effacement on the thecal sac, but no encroachment on the proximal L4 roots. Mild facet joint disease is seen. At L4-L5 there is a larger central and paracentral protrusion with eccentricity to the right compared to L3-L4. There is an associated prominent annular tear. The protrusion measures 5 mm with slight effacement of the thecal sac centrally and to the right at the exit point of the right L5 rootlets. The rootlets are not displaced. There is low grade facet joint disease. At L5-S1 no protrusion or broad based disc bulge is noted. There is a relatively overall decreased marrow signal on the T1, weighted images suggesting diffuse red marrow conversion. This can be seen with multiple disorders with anemia possibility- correlate with a CBC. A request for a lumbar epidural steroid injection is denied due to the following absence of documentation; MRI for review, objective examination findings consistent with MRI evidence of stenosis, objective specific sign of radiculopathy and the level of weakness, per Utilization Review letter dated August 25, 2015. The medication list include Naproxen, Protonix and Flexeril. Per the note dated 8/4/15 the patient had complaints of low back pain and left leg pain at 4/10 Physical examination of the lumbar spine revealed positive SLR, limited range of motion and 4/5 strength. The patient had received an unspecified number of PT visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The MTUS Chronic Pain Guidelines regarding Epidural Steroid Injections state, "The purpose of ESI 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. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." Per the cited guideline criteria for ESI are "1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)." Patient has received an unspecified number of PT visits for this injury. Conservative therapy notes were not specified in the records provided. A response to recent rehab efforts including physical therapy or a continued home exercise program were not specified in the records provided. As stated above, epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The records provided did

not specify a plan to continue active treatment programs following the lumbar ESI. As stated above, ESI alone offers no significant long-term functional benefit. Evidence of diminished effectiveness of medications or intolerance to medications (including anticonvulsants) was not specified in the records provided. With this, it is deemed that the request for Lumbar epidural steroid injection is not medically necessary or fully established for this patient.