ADVANCED MEDICAL STRATEGIES
PHYSICIANS. TAKING CARE OF BUSINESS.

February 11, 2015

Upon request of GWIS a medical opinion regarding the treatment provided was conducted on the above patient. Our findings are documented below:

Clinical Summary:

This is a 32-year-old male patient diagnosed with a sprain of the back and lumbar pain following a work-related injury on 09/03/14. The mechanism of injury was described as occurring while the patient was shoveling slag from the plasma table, and hurt his back. Pain management has requested an epidural steroid injection, which is the subject of this review.

On 09/04/14, the patient was referred for physical therapy and work restrictions were placed. On 09/26/14, the patient presented for recheck reporting a pain level of five out of ten, and describing pain in the low back with radicular pain into the left leg and foot as well as numbness and tingling that occurs when he is in flexion and extension of low back. On exam, there was pain with range of motion. A straight leg raise produced pain in the back. Strength and sensation were not tested. The patient had completed six sessions of physical therapy as of 09/26/14. On 10/03/14, the patient returned for a recheck with complaints of back pain rated at four out of ten. He reports he still has numbness in the left leg down to the foot and pain when he tries to sleep. It hurts when he walks and bends. He has been working modified duty. The physical exam revealed pain into the left leg on a left straight leg raise. Strength and sensation were not tested. On 10/13/14, the patient returned, continuing to complain of left back pain that hurts when he lifts things and when he gets up from sitting. He has pain into the left leg. It was noted he does not have the numbness like he used to. Current medications included cyclobenzaprine, ibuprofen, Medrol Dosepak, lisinopril, and metformin. A physical exam revealed pain with lumbar range of motion. A straight leg raise was positive for pain into the left leg down to the knee. Toe walk was painful. DTRs (deep tendon reflexes) were 1+ (one plus) at the bilateral patella. Strength and sensation were not tested. An MRI (magnetic resonance imaging) of the lumbar spine performed on 10/18/14 revealed L5-S1 (lumbar to sacral) desiccation and loss of normal water content. There is a two mm (millimeter) right L5-S1 disc herniation with increased signal within the posterior margin of the disc herniation, which may be seen in acute to sub-acute disc herniations. On 10/21/14, it was noted that the patient returned with complaints of left low back pain and SI (sacroiliac) pain. It was noted he continues to report numbness in the left foot. He has been compliant with physical therapy and his HEP (home exercise program). Pain was rated at five out of ten with radiation to the left thigh, left calf, left great toe and left lateral foot. It was noted that the symptoms are worsening. On exam, he has pain into the left leg on straight leg raise. The plan was to continue PT (physical therapy). On the PT progress note dated 10/30/14, it was noted the patient had completed 12 sessions of physical therapy. The patient presented on this date reporting no pain, just muscle soreness in the back. Radicular pain is gone. Patient reported performing his home exercise program daily. On 11/03/14, the patient returns again for follow-up reporting low back pain and stating that the numbness is still in the left leg to the foot. It was reported he has been at light duty and says majority of the time his leg remains numb. On exam, lumbar range of motion was restricted and painful. He has pain into the left leg on straight leg raise. There was numbness

present down to the top of the foot. On 11/13/14, the patient presented with ongoing complaints of left leg pain and numbness into the left foot. It was noted he saw pain management and is planning to try an injection. On 12/10/14, the patient returned with no change in symptoms or exam findings. The plan was to continue PT while awaiting authorization for an epidural steroid injection.

Questions:

1. Please review the medical treatment up to this point and determine if the request for an ESI is directly related to the mechanism of injury described by the claimant when he was injured on 9/3/14?

2. Does the Lumbar MRI dated 10/18/14 indicate a traumatic injury or a chronic condition?

3. If it is decided that the request for pain management is not directly related to the mechanism of injury described on 9/3/14, would the claimant then have reached MMI for his injury of 9/3/14?

4. If it is decided that pain management is the next step in the claimant's treatment for his injury of 9/3/14, when could MMI be anticipated?

Conclusions*:

1. Please review the medical treatment up to this point and determine if the request for an ESI is directly related to the mechanism of injury described by the claimant when he was injured on 9/3/14?

The requested ESI is directly related to the mechanism of injury described by the claimant when he was injured on 9/3/14. The patient reported injuring his back while shoveling slag from the plasma table. The MRI revealed a two mm (millimeter) right L5-S1 (lumbar to sacral) disc herniation with increased signal within the posterior margin of the disc herniation which may be seen in acute to sub-acute disc herniations. Objective findings are consistent with the described work-related injury and an ESI would be a standard of care treatment option for patients who have subjective complaints of radiculopathy corroborated by imaging and have failed conservative treatment measures.

2. Does the Lumbar MRI dated 10/18/14 indicate a traumatic injury or a chronic condition?

The lumbar MRI dated 10/18/14 indicates a traumatic injury. It was noted there is a two mm right L5-S1 disc herniation with increased signal within the posterior margin of the disc herniation which may be seen in acute to sub-acute disc herniations.

3. If it is decided that the request for pain management is not directly related to the mechanism of injury described on 9/3/14, would the claimant then have reached MMI for his injury of 9/3/14?

N/A

4. If it is decided that pain management is the next step in the claimant's treatment for his injury of 9/3/14, when could MMI be anticipated?

Given ongoing radicular complaints, objective findings on MRI of herniated disc, and failure of conservative treatment including physical therapy and appropriate pharmacological agents, performance of an epidural steroid injection with pain management would be an appropriate next step. It would be expected that the patient would be considered at MMI within four to six weeks pending response to injections.

Reference(s):

1. Practice Guidelines for Chronic Pain Management: An Updated Report by the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine Anesthesiology: April 2010 - Volume 112 - Issue 4 - pp 810-833 doi: 10.1097/ALN.0b013e3181c43103

2. Laxmaiah Manchikanti, Mark V. Boswell, Vijay Singh, Ramsin M. Benyamin; American Society of Interventional Pain Physicians Comprehensive Evidence-Based Guidelines for Interventional Techniques in the Management of Chronic Spinal Pain; Pain Physician; 2009; 12(4):699-802

3. Benyamin RM, Manchikanti L, Parr AT, Diwan S; The Effectiveness of Lumbar Interlaminar Epidural Injections in Managing Chronic Low Back and Lower Extremity Pain; Pain Physician; 2012; 15(4):E363-404

4. The Official Disability Guidelines, Low Back, Epidural Steroid Injections

Reviewer's Credentials

Is a medical doctor (MD) board certified in physical medicine and rehabilitation and pain medicine with and active practice. Serves as medical director in pain program and attending physician at a rehabilitation hospital. Staff physician in pain medicine and physical medicine and rehabilitation at a neurosurgery and spinal center. Active in the field of research.

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