

<b>Case Number:</b>	CM14-0102743		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	12/27/2011
<b>Decision Date:</b>	10/20/2014	<b>UR Denial Date:</b>	06/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/03/2014

### 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 Neurological Surgery and is licensed to practice in Texas and Michigan. 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 27 year old female who had a work related injury on 12/27/11. The mechanism of injury was not described. The diagnosis was lumbar radiculopathy secondary to neural foraminal stenosis at left L5-S1 causing compression of exiting L5 nerve root. A magnetic resonance imaging of the lumbosacral spine on 02/27/12 was consistent with broad posterior disc bulge measuring 2-3mm at L5-S1. There was left neural foraminal narrowing but it caused compression finding L5 nerve root. An electromyography (EMG)/nerve conduction study (NCS) on 01/14/13 was consistent with either left peroneal neuropathy or left L5 radiculopathy. Flexion/extension views of the lumbosacral spine demonstrated no instability. However there was significant neural foraminal narrowing at L5-S1 caused by superior facet of S1. Most recent clinical documentation submitted for review was dated 05/12/14 she had physical therapy, chiropractic manipulation medications prescribed. Low back pain subsided somewhat with limited improvement. The injured worker returned due to increased frequency of pain associated with numbness and tingling and weakness progressing over previous week. On physical examination, the patient appeared to be in moderate distress. Cranial nerves 2-12 were grossly intact. A physical examination of lumbar spine revealed normal gait. She could walk on heels and toes with difficulty due to left hip pain and her pelvis was level. There was straightening of lumbar lordosis. There was tenderness to L5-S1 and left lumbar paravertebral muscle spasm. There was marked stiffness of the left hip and knee. There was low back pain throughout the arc of motion. There was severe guarding to deep palpation on the left lower extremity and associated severe myofascial pain that was reproduced on deep palpation of lumbar paraspinal muscles. The range of motion included a flexion of 70 degrees, extension of 20, bilateral lateral flexion of 30 and bilateral rotation of 35. Straight leg raise test was severely positive on the left leg starting at 25 degrees angle with reproduction of sharp shooting pain matching dermatomal

distribution at L5-S1 in both the seated and supine position. The patient ambulated normal with a mild limp. Heel and toes tests were performed with some difficulty patient was not able to squat fully due to muscle spasm. The quadriceps, hamstrings, and gastrocsoleus were rated 4/5 bilaterally, ankle dorsiflexors were rated 4/5 bilaterally, there was a negative Lasegue's test, tenderness to palpation in the left sciatic notch. The injured worker had a positive Gaenslen's sign and sacral joint thrust sign sensation intact to light touch in the lower extremities. The diagnosis included lumbar musculotendinous injury, lumbar paraspinal muscle spasms, lumbar disc herniation, lumbar spine radiculitis/radiculopathy of lower extremities, and sacroiliitis of the left sacroiliac joint. Prior utilization review on 06/03/14 was non-certified. Current request was for left transforaminal lumbar epidural steroid injection at L5-S1 under fluoroscopic guidance.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**1ST LT Transforaminal Lumbar Epidural Steroid Injection @ L5-S1 under fluoroscopy guidance:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lumbar Epidural Steroid Injection. Decision based on Non-MTUS Citation Official Disability Guidelines: TWC: Hip & Pelvis Procedure Summary 3/25/2014

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines, epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The physical exam revealed straight leg raise test severely positive on the left leg starting at 45 degrees angle with reproduction of sharp shooting pain matching dermatomal distribution at L5-S1 in both the seated and supine position. A magnetic resonance imaging of the lumbosacral spine on 02/27/12 was consistent with broad posterior disc bulge measuring 2-3mm at L5-S1. There was left neural foraminal narrowing that caused compression finding L5 nerve root. EMG/NCS on 01/14/13 was consistent with either left peroneal neuropathy or left L5 radiculopathy. Per California MTUS a radiculopathy must be documented and objective findings on examination need to be present. Additionally, Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. Therefore medical necessity has been established.