

<b>Case Number:</b>	CM14-0021709		
<b>Date Assigned:</b>	05/07/2014	<b>Date of Injury:</b>	02/12/2001
<b>Decision Date:</b>	08/06/2014	<b>UR Denial Date:</b>	01/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2014

### 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 Occupational 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 patient is a 69-year-old female who has submitted a claim for lumbar/lumbosacral disc degeneration, acquired spondylolisthesis, and pain in joint lower leg; associated with an industrial injury date of 02/12/2001. Medical records from 2013 to 2014 were reviewed and showed that patient complained of neck and low back pain radiating to the left lower extremity. Physical examination showed tenderness along the lower thoracic and lumbar spine, left paraspinal musculature of the lower thoracic spine and medial border of the left scapula. Seated straight leg raise test was positive on the left. Achilles and patellar reflexes were 1+. Weakness of knee flexion and plantar flexion of the ankle was noted. Sensation was decreased throughout the distal lower left extremity, not in a particular dermatomal distribution. MRI of the cervical spine, dated 11/13/2011, did not show significant neural foraminal stenosis or nerve root compromise. EMG of the lower extremities, dated 07/29/2011, revealed chronic left L3-L4 and right S1 radiculopathy with ongoing denervation. Treatment to date has included medications, acupuncture, TENS, chiropractic therapy, and physical therapy. Utilization review, dated 01/21/2014, denied the request for epidural steroid injection because there was no evidence of functional improvement or reduction of medication intake since previous ESI; and denied the request for diclofenac because guidelines do not recommend prescription of Voltaren gel greater than 1% and has not been evaluated for treatment of the spine, and the patient claims to be allergic to NSAIDs. An appeal letter, dated 02/11/2014, stated that patient has exhausted all conservative treatment and repeat ESI can hopefully provide pain relief and decrease topical medication use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ONE LEFT TRANSFORAMINAL LUMBAR EPIDERMAL STEROID INJECTION AT L4-L5 WITH SEDATION AND FLUOROSCOPIC GUIDANCE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection.

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

**Decision rationale:** As stated on page 46 of the CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injections (ESI) are recommended as an option for treatment of radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Also, the patient must be initially unresponsive to conservative treatment. 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. In this case, the patient complains of low back pain accompanied by radicular symptoms despite medications and physical therapy. On physical exam, straight leg raise test was positive on the left. Sensation was decreased throughout the distal lower left extremity, but not in a particular dermatomal distribution. However, MRI of the cervical spine, dated 11/13/2011, did not show significant neural foraminal stenosis or nerve root compromise; and EMG of the lower extremities, dated 07/29/2011, failed to show radiculopathy in the L4-L5 level. The patient has had ESI on 11/12/2013, and reported 50% pain relief for one month. However, there was no discussion regarding functional benefits, or reduction of medication usage derived from it. Also, guidelines require 6-8 weeks of pain relief for repeat ESI. The criteria for ESI have not been met. Therefore, the request for one left transforaminal lumbar epidermal steroid injection at L4-L5 with sedation and fluoroscopic guidance is not medically necessary.

**ONE PRESCRIPTION OF DICLOFENAC SODIUM 1.5% 60 GM #1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : Topical analgesics Page(s): 112-113.

**Decision rationale:** As stated on pages 112 to 113 of the CA MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Voltaren Gel 1% (diclofenac) is recommended for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, the patient complains of neck and back pain with radicular symptoms despite conservative

therapy. However, it has not been evaluated for treatment of the spine. The rationale for this request is unclear. Therefore, the request for one prescription of diclofenac sodium 1.5% 60 gm #1 is not medically necessary.