

<b>Case Number:</b>	CM14-0045392		
<b>Date Assigned:</b>	04/30/2014	<b>Date of Injury:</b>	05/03/2005
<b>Decision Date:</b>	06/12/2014	<b>UR Denial Date:</b>	03/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/01/2014

### 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 Clinical Psychology 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 54 year old male who was injured on 05/03/2005 while having been involved in a motor vehicle accident. He had also fallen down several stairs on 11/06/2013 twisting his back and falling forward. Prior treatment history has included the patient receiving 12 physical therapy treatments from 01/03/2012 to 02/13/2012 for treatment of lumbar stenosis. Therapy consisted of an aquatic exercise program and land based program of active, passive, stretching and lumbar stabilization exercises. On 09/20/2011, he underwent a right L5-L6 hemilaminotomy and foraminotomy. He is currently on Norco 10/325 mg four times a day. He has been on hydrocodone, gabapentin and Ambien. A physical therapy note dated 02/13/2012 assessed that the patient's range of motion in right and left rotation has improved. His posture has gotten better as well. He was instructed on a home exercise program. Diagnostic studies reviewed include plain x-rays of the lumbar spine 02/17/2014 revealing L5-L6 spinal segment and postoperative changes on the right at L5-L6. MRI of the lumbar spine dated 02/17/2014 shows postoperative changes on the right at L5-L6 with L4-L5 central spinal canal stenosis with facet hypertrophy dorsally and a contained annular bulge ventrally. A progress note dated 02/18/2014 documented the patient had a long course of treatment and was noted to have a right L5-L6 disc herniation. His leg pain is worse than his low back pain. His right leg is more symptomatic than the left. He has plantar foot numbness bilaterally. The pain in his right leg involves the anterior thigh, shin, calf and foot. The left leg involves the posterolateral thigh and plantar foot area. Aggravating factors include walking more than several blocks, standing more than 10 minutes, lifting more than 10 pounds and getting out of bed or inactivity. He does not use a cane or a crutch. Objective findings on exam reveal a 3" scar over the right L5-L6 spinal segment. Lumbar lordosis was unremarkable. The sciatic nerve stretch test was negative. There was decreased sensation in the right leg in a non-anatomic "hip boot" distribution. Motor strength is 5/5 in all muscle groups.

His hip and knee examination was normal. DTRs were 1+ at the knees and his ankle deep tendon reflex was absent on the right and 1+ on the left. Impressions included: two and a half years status post right L5-L6 foraminotomy for spinal stenosis; and L4-5 and L5-6 spinal stenosis with neurogenic claudication. Bilateral L4-L5 transforaminal epidural steroid injections were recommended. A progress note dated 04/24/2014 documents the patient stating the pain in his right leg is coming back, mainly in the thigh. His feet are numb but that is chronic. It is aggravated by prolonged sitting. Objective examination of the back reveals above the incision he has some localized tenderness as well as in the right sacroiliac joint. Straight leg raising was positive on the right. He appeared to have a mild foot drop on the right. Knee jerks were trace bilaterally. Ankle jerks were not elicited.

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

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

**BILATERAL L4-L5 TRANSFORAMINAL EPIDURAL STEROID INJECTION:** 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 Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

**Decision rationale:** The California MTUS guidelines state that the purpose of an 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. The guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. However, the lumbar MRI dated 02/17/2014 shows postoperative changes on the right at L5-L6 with L4-L5 bulge, central spinal canal stenosis and facet hypertrophy. There is no evidence of nerve root compromise at L4-5 level consistent with radiculopathy. Also, the physical exam showed sciatic nerve stretch test was negative, decreased sensation in the right leg in a non-anatomic distribution, motor strength 5/5 in all muscle groups, and DTRs 1+ symmetrical. These findings are not enough evidence of radiculopathy to warrant the ESI. Therefore, the requested ESI is not medically necessary or appropriate.