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| <b>Case Number:</b>   | CM14-0047982 |                              |            |
| <b>Date Assigned:</b> | 07/02/2014   | <b>Date of Injury:</b>       | 09/19/1996 |
| <b>Decision Date:</b> | 09/25/2014   | <b>UR Denial Date:</b>       | 03/10/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/16/2014 |

### 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 Physical Medicine and Rehabilitation, has a subspecialty in PainMedicine and is licensed to practice in Texas and Oklahoma. 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 48 year old male who reported a twisting injury on 09/19/2006. The diagnoses included failed back surgery syndrome, lumbar disc disease, and degenerative joint disease. The past treatments included medications, physical therapy, and transcutaneous electrical nerve stimulation (TENS). It was also documented that the injured worker previously had epidural steroid injections related to a non-industrial injury. An MRI of the lumbar spine dated 10/31/2013, revealed mild degenerative changes at L4-5 with minimal central canal narrowing, post-surgical changes from previous left laminectomy at L5-S1, soft tissue material at the left paracentral region of L5-S1, and a small focal disc extrusion versus granulation tissue displacing the left S1 nerve root posteriorly. Surgical history noted a laminectomy in 1999. The progress note dated 04/15/2014 noted the injured worker complained of unchanged pain rated 5/10. The physical exam revealed low back pain with left posterior radicular pain corroborated with the S1 nerve, positive straight leg raise to the left leg at 45 degrees, Achilles reflexes absent bilaterally, patellar reflexes 1+ on the left and absent on the right, with numbness to the bottom of his foot, and 4/5 motor strength, slightly weaker on the left with flexion. Medications included Percocet 5/325mg and Motrin. The treatment plan requested the left L5-S1, and left S1 epidural steroid injection, to consider a medial branch block at the same levels, to refill Percocet 5/325mg 4 times daily, a 15 day starter pack of Gralise (Gabapentin) continue TENS, Motrin, and activity as tolerated. The Request for Authorization form was submitted for review 03/03/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transforaminal epidural steroid injection (ESI) Left at L5-S1: 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 request for transforaminal epidural steroid injection (ESI), left at L5-S1 is not medically necessary. The injured worker had low back pain, rated 5/10, with left posterior radicular pain corroborated with S1, a positive straight leg raise to the left, 1+ left patellar reflex and otherwise absent deep tendon reflexes bilaterally, numbness to the bottom of his foot, and 4/5 motor strength. The California MTUS guidelines indicate the criteria for ESI includes documentation of radiculopathy on physical exam in the applicable dermatomal distribution with corroborative findings of radiculopathy, supported by imaging or electrodiagnostic testing, and a failed response to conservative treatment. There was documentation of radicular pain to the S1 dermatomal distribution, indication of decreased sensation to the bottom of the foot, representing the L5-S1 dermatomal distribution. There was evidence to support the injured worker has tried medications, physical therapy, and transcutaneous electrical nerve stimulation with continued pain. The MRI at L5-S1 provided report of soft tissue displacement of the left S1 nerve. There was documentation of a prior epidural steroid injection, but it was noted to be treatment of an unrelated injury. With documentation of radicular pain and symptoms noted to the appropriate dermatomal level, corroborated by imaging, and the evidence of failure with more conservative treatment modalities, a left L5-S1 epidural steroid injection would be supported. However, the submitted request does not indicate whether the injection will be performed under fluoroscopic guidance. Therefore, the request is not medically necessary.