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| <b>Case Number:</b>   | CM14-0088880 |                              |            |
| <b>Date Assigned:</b> | 07/23/2014   | <b>Date of Injury:</b>       | 12/21/2009 |
| <b>Decision Date:</b> | 08/27/2014   | <b>UR Denial Date:</b>       | 05/22/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/12/2014 |

### 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 Interventional Spine 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 63-year-old male with date of injury of 12/21/2009. The listed diagnoses per [REDACTED] dated 05/22/2014 are: 1. Lumbar disk disease. 2. Lumbar radiculopathy. 3. Lumbar facet syndrome. 4. Status post left knee arthropathy. According to this report, the patient complains of low back pain and left knee pain which he rates 8/10 on the pain scale. He notes that the pain has remained unchanged since his last visit. He states that he is scheduled to undergo a left knee arthroscopic surgery on 05/24/2014. He already has been taking his medications for hypertension and allergies. The physical exam shows the patient is well developed, well nourished, in no apparent distress. The patient's gait is antalgic on the left with the use of a cane. Heel-to-toe walk exacerbates the antalgic gait on the left. Visual examination of the lumbar spine shows normal lordosis and alignment. There is diffuse tenderness noted to palpation over the lumbar paraspinal muscles. There is moderate-to-severe facet tenderness noted along the L3 through S1 level. Kemp's test is positive bilaterally. Seated straight leg raise is positive on the left at 50 degrees, and supine straight leg raise is positive on the left at 40 degrees. The patient has decreased sensation in the L3 and L4 dermatomes on the left. The utilization review denied the request on 05/22/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Transforaminal Epidural Steroid Injection Lumbar 3-Lumbar 4 and Lumbar 4-Lumbar 5:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines The Medical Treatment Utilization Schedule has the following regarding ESI's, under its chronic pain section Page(s): 46, 47.

**Decision rationale:** This patient presents with chronic low back pain that radiates down the bilateral legs, left greater than the right. The treater is requesting left transforaminal epidural steroid injection at L3-L4 and L4-L5. The MTUS Guidelines pages 46 and 47 on epidural steroid injection recommends this option for treatment of radicular pain, as defined by pain in a dermatomal distribution with corroborative findings in an MRI. No more than 2 nerve root levels should be injected using transforaminal blocks. In addition 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 with a general recommendation of no more than 4 blocks per region per year. The progress report dated 04/24/2014 references an MRI of the lumbar spine dated 05/23/2013 that shows a 4.7-mm disk protrusion effacing the sac and facet hypertrophy at L3-L4. At L4-L5, there is a 4.8-mm diffuse disk protrusion with facet hypertrophy narrowing the neuroforamen. In the same progress report, the treater documents moderate-to-severe facet tenderness along the L3 through S1 level, with a positive left straight leg raise on the left and decreased sensation in the L3-L4 dermatomes on the left. Also referenced was a lumbar epidural injection performed by Dr. Cohen approximately a year ago from which the patient experienced 50% pain relief for more than 2 to 3 months. No documentations are provided regarding functional improvement or medication reduction. In this case, while the patient has leg symptoms, they are diffuse in a non-dermatomal distribution. MRI shows disc protrusion but they are centrally located and does not involve a nerve root. While protrusions can result in nerve root irritation, this patient does not present with a convincing diagnosis of radiculopathy. Furthermore, prior injection did not result in documentation of functional improvement or reduction in medication use. Recommendation is for denial.