

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM14-0128850 |                              |            |
| <b>Date Assigned:</b> | 08/18/2014   | <b>Date of Injury:</b>       | 10/27/2010 |
| <b>Decision Date:</b> | 01/02/2015   | <b>UR Denial Date:</b>       | 07/16/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/13/2014 |

### 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:

Patient is a 42 year-old male with date of injury 10/27/2010. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 07/08/2014, lists subjective complaints as pain in the low back. Patient is status post lumbar epidural steroid injection on the left side on 06/19/2014 with mild improvement. Objective findings: Examination of the lumbar spine revealed tenderness to palpation of the paraspinal muscles; increased pain with lumbar extension and rotation, with compression over the facet joints of L4-5 and L5-S1 bilaterally. Straight leg rising was negative bilaterally. Injured worker had full range of motion of the hips bilaterally. Diagnoses are:

1. Degeneration of lumbosacral intervertebral disc
2. Displacement of lumbar intervertebral disc
3. Spinal stenosis without neurogenic claudication
4. Lumbago. The medical records supplied for review document that the patient was prescribed the following medication on 07/08/2014. Medications: Lidocaine 5% Ointment 1-2gm, #100 SIG: QID PRN.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral L5-S1 transforaminal epidural steroid injection:** 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:** According to the MTUS, several diagnostic criteria must be present to recommend an epidural steroid injection. The most important criteria are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In the therapeutic phase, 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 six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. The patient had only mild improvement with his last epidural steroid injection. Bilateral L5-S1 transforaminal epidural steroid injection is not medically necessary.

**Pain management follow-up x 6 monthly:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Low Back

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 7, Independent Medical Examinations and Consultations, Page 132

**Decision rationale:** According to the MTUS, a referral request should specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, workability, clinical management, and treatment options. The medical record lacks sufficient documentation and does not support a request for additional treatment by a pain specialist as medically necessary and appropriate.

**Lidocaine 5% ointment 1-2gm Qty: 100:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 56.

**Decision rationale:** Topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. The patient does not suffer from post-herpetic neuralgia or localized peripheral pain. Lidocaine 5% ointment 1-2gm Qty: 100 are not medically necessary.

