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| <b>Case Number:</b>   | CM14-0148320 |                              |            |
| <b>Date Assigned:</b> | 11/18/2014   | <b>Date of Injury:</b>       | 02/26/2014 |
| <b>Decision Date:</b> | 01/20/2015   | <b>UR Denial Date:</b>       | 08/13/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/12/2014 |

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 46-year-old male who has submitted a claim for lumbar spine radiculitis to the right lower extremity associated with an industrial injury date of 2/26/2014. Medical records from 2014 were reviewed. The patient complained of persistent low back pain radiating to bilateral lower extremities associated with numbness and tingling sensation. Physical examination showed limited lumbar motion, tenderness and spasm over paralumbar muscles, positive straight leg raise test at the left, weakness of left tibialis anterior/EHL/gastrocsoleus, diminished reflexes throughout and normal sensory. The MRI of the lumbar spine on 3/6/2014 showed a 6-7 mm large right paracentral disc protrusion with marked right foraminal narrowing and milder left foraminal narrowing. The disc protrusion contacts the traversing nerve roots to the right of midline. A repeat MRI of the lumbar spine, dated 6/25/2014, demonstrated a 3-4 mm right greater than left broad-based posterior disc protrusion at L4-L5 resulting in moderate L4-L5 lateral recess stenosis with potential for impingement on the traversing L5 nerves bilaterally. There is a moderate right and mild left L4-L5 foraminal stenosis. A 2 mm curvilinear annular fissure at the posterior-inferior L4-L5 disc margin is also identified. The x-ray of the lumbar spine, dated 3/13/2014, showed lumbarized sacral level. Treatment to date has included physical therapy, chiropractic care, acupuncture, and medications. The utilization review from 8/13/2014 denied the request for caudal ESI injection at L4-5 with fluoroscopic guidance because of lack of evidence of failure in conservative care.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Caudal ESI injection at L4-5 with fluoroscopic guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

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

**Decision rationale:** As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. In this case, the patient complained of persistent low back pain radiating to bilateral lower extremities associated with numbness and tingling sensation. Physical examination showed limited lumbar motion, tenderness and spasm over paralumbar muscles, positive straight leg raise test at the left, weakness of left tibialis anterior/EHL/gastrocsoleus, diminished reflexes throughout and normal sensory. The MRI of the lumbar spine on 3/6/2014 showed a 6-7 mm large right paracentral disc protrusion with marked right foraminal narrowing and milder left foraminal narrowing. The disc protrusion contacts the traversing nerve roots to the right of midline. A repeat MRI of the lumbar spine, dated 6/25/2014, demonstrated a 3-4 mm right greater than left broad-based posterior disc protrusion at L4-L5 resulting in moderate L4-L5 lateral recess stenosis with potential for impingement on the traversing L5 nerves bilaterally. There is a moderate right and mild left L4-L5 foraminal stenosis. A 2 mm curvilinear annular fissure at the posterior-inferior L4-L5 disc margin is also identified. The documented rationale for ESI is due to failure in conservative management involving physical therapy, chiropractic care, acupuncture, and medications. Clinical manifestations are consistent with radiculopathy and corroborated by imaging. However, it is unclear if the plan is to perform ESI at both sides since there is no significant foraminal stenosis at the left L4-L5 level to warrant the procedure. Therefore, the request for caudal ESI injection at L4-5 with fluoroscopic guidance is not medically necessary.