

<b>Case Number:</b>	CM14-0189299		
<b>Date Assigned:</b>	11/18/2014	<b>Date of Injury:</b>	05/19/2004
<b>Decision Date:</b>	01/07/2015	<b>UR Denial Date:</b>	10/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/11/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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 52-year-old presenting with low back pain and left knee pain. The patient had a work-related injury on 05/19/2004. The patient is status post lumbar spine surgery in 2000. The patient complained of abnormal gait, back pain, muscle spasms, numbness, tingling, and weakness. The physical exam was significant for spasms and tenderness over the paravertebral muscles bilaterally and tenderness along the,; positive lumbar facet loading and straight leg raise bilaterally; pinprick is slightly decreased at the S1 distribution bilaterally; atrophy on the left calf and by also noted; as well as 4 to 5 strength for the left leg. The patient has started physical therapy session, pool therapy and acupuncture with noted benefit. MRI of the lumbar spine showed multilevel degenerative disc disease, multilevel congenital narrowing of the canal L1 - L2 to L2 - L3 - L4, with affectation at L4 - L5 and less so at L5 - S1; there is some foraminal stenosis bilaterally but not severe. The patient's medications included docusate, Lyrica, and said, ibuprofen, omeprazole, Cymbalta, Percocet, amitriptyline, morphine sulfate ER 30 mg every 12 hours and Metformin. The patient was diagnosed with lumbar disc disorder, lumbar radiculopathy, and knee pain. A claim was placed for a transforaminal lumbar epidural steroid injection at L5-S1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transforaminal Lumbar Epidural Injection (L5-S1, Bilateral):** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transforaminal Epidural Injection.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 47.

**Decision rationale:** I am reversing the prior UR decision. Transforaminal Lumbar Epidural Injection (L5-S1, Bilateral) is medically necessary. The California MTUS page 47 states "the purpose of epidural steroid injections 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 is no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment, injections should be performed using fluoroscopy, if the ESI is for diagnostic purposes a maximum of 2 injections should be performed. No more than 2 nerve root levels should be injected using transforaminal blocks. No more than 1 interlaminar level should be injected at one session. 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 6-8 weeks, with the general recommendation of no more than 4 blocks per region per year. Current research does not support a series of 3 injections in either the diagnostic or therapeutic phase. We recommend no more than 2 epidural steroid injections." The physical exam and MRI results does corroborate lumbar radiculitis for which the procedure was requested. The claimant did exhibit neurological deficit; in the dermatomal distribution to be treated with an epidural steroid injection. The requested service is medically necessary.