

<b>Case Number:</b>	CM14-0195614		
<b>Date Assigned:</b>	12/03/2014	<b>Date of Injury:</b>	11/11/2012
<b>Decision Date:</b>	01/23/2015	<b>UR Denial Date:</b>	11/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2014

### 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 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 37-year-old male who has submitted a claim for lumbar disc herniation at L5 to S1, lumbar disc degenerative disease, and lumbar radiculitis associated with an industrial injury date of November 11, 2012. Medical records from 2014 were reviewed. The patient complained of low back pain associated with numbness and tingling sensation at the left lower extremity. The pain was rated 7/10 in severity and relieved to 4/10 with medications. Aggravating factors included sitting and lifting. Physical examination showed a normal heel-to-toe pattern during gait. The patient was in no acute distress. There were no findings pertaining to the lumbar spine and bilateral lower extremities. The MRI of the lumbar spine, undated, demonstrated broad based central disc herniation with left paracentral disk protrusion component at L5 to S1. There was moderate bilateral facet arthrosis. There was no evidence of nerve root impingement. Treatment to date has included left L5 to S1 laminectomy with lateral recess decompression and discectomy, nerve root dissection with microscopic dissection, and injection of epidural Depo-Medrol on December 4, 2013, physical therapy, and medications. The utilization review from November 14, 2014 denied the request for left L5-S1 epidural steroid injection qty: 1.00 because of no evidence of active radiculopathy supported by examination and diagnostic study findings.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left L5-S1 epidural steroid injection QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injection ESIs 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 low back pain associated with numbness and tingling sensation at the left lower extremity. The pain was rated 7/10 in severity and relieved to 4/10 with medications. Aggravating factors included sitting and lifting. Physical examination showed a normal heel-to-toe pattern during gait. The patient was in no acute distress. The MRI of the lumbar spine, undated, demonstrated broad based central disc herniation with left paracentral disk protrusion component at L5 to S1. There was moderate bilateral facet arthrosis. There was no evidence of nerve root impingement. Symptoms persisted despite left L5 to S1 laminectomy with lateral recess decompression and discectomy, nerve root dissection with microscopic dissection, and injection of epidural Depo-Medrol on December 4, 2013, physical therapy, and medications. However, there were no findings pertaining to the lumbar spine and bilateral lower extremities to document radiculopathy. The imaging results also failed to show evidence of nerve root impingement to warrant ESI. Guideline criteria were not met. Therefore, the request for left L5-S1 epidural steroid injection qty: 1.00 was not medically necessary.