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| <b>Case Number:</b>   | CM14-0205624 |                              |            |
| <b>Date Assigned:</b> | 12/17/2014   | <b>Date of Injury:</b>       | 02/22/2010 |
| <b>Decision Date:</b> | 02/25/2015   | <b>UR Denial Date:</b>       | 11/26/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/08/2014 |

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabn

### 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 57 year old female with an injury date of 02/22/10. Based on the 06/25/14 progress report provided by treating physician, the patient complains of lower back pain radiating to left leg. Physical examination to the back revealed tender lumbar spine. Submitted progress reports were handwritten with minimal information for review. Per UR letter patient has had previous ESI that provided pain relief. Patient's current medications include Lidoderm patches, Flexeril and Ambien. Patient is totally disabled. MRI of the lumbar spine 08/27/14: L4-5 - There are mild bilateral facet degenerative changes and ligamentum flavum hypertrophy. There is mild-to-moderate disc space narrowing. There is a broad based disc protrusion, greater in AP diameter in the left paracental and left neural foraminal area, measuring a maximal of 3 mm in AP diameter. There is no central canal narrowing. There is mild to moderate left and mild right lateral recess narrowing. There is mild left neural foraminal narrowing. L5-S1: There is mild disc desiccation. There are mild degenerative endplate changes. There are mild bilateral facet degenerative changes. There is no disc protrusion or extrusion, spinal stenosis or neural foraminal narrowing. Diagnosis (12/10/14)- Failed back syndrome. The utilization review determination being challenged is dated 11/26/14. The rationale follows: "there is no documentation of the percentage of improvement or documentation of decreased medication reliance. Treatment reports were provided from 04/09/14 to 12/10/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient left L4-L5 and L5-S1 transforaminal epidural steroid injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 45.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46, 47. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) L-spine chapter under ESI.

**Decision rationale:** The patient presents with lower back pain radiating to left leg. The request is for outpatient left L4-L5 and L5-S1 transforaminal epidural steroid injection. Per UR letter patient has had previous ESI that provided pain relief. Patient's current medications include Lidoderm patches, Flexeril and Ambien. Patient is totally disabled. MTUS page 46, 47 states that an ESI is "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." MTUS further states, "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." For post-op, ODG guidelines L-spine chapter under ESI states, "Not recommended post-op. The evidence for ESI for post lumbar surgery syndrome is poor."Treater has not given reason for the request. Submitted progress reports were handwritten with minimal information for review. UR letter dated 11/26/14 states patient previously had ESI but treater did not submit any documentation nor discussion on how the patient responded. MTUS requires documentation of objective pain and functional improvement, including at least 50% pain relief with associated reduction of medication use, which has not been provided. The patient does present with left leg symptoms but no MRI reports are provided and the treater does not discuss its findings to show radiculopathy. The patient is post-op as well for which ODG guidelines do not support an ESI. Given the lack of documentation submitted by treater for review, the request does not meet guideline indications. Therefore, the request is not medically necessary.