

<b>Case Number:</b>	CM15-0189784		
<b>Date Assigned:</b>	10/01/2015	<b>Date of Injury:</b>	02/12/2015
<b>Decision Date:</b>	11/13/2015	<b>UR Denial Date:</b>	08/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2015

### 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 & Rehabilitation

### 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 injured worker is a 35 year old male, who sustained an industrial injury on 02-12-2015. He has reported subsequent low back pain and was diagnosed with herniated nucleus pulposus at L5-S1 and lumbar stenosis. MRI findings on 04-22-2015 revealed L5-S1 bulge with left lateral recess protrusion with mild central canal and left lateral recess narrowing. The physician also noted that upon review, there was left lateral recess stenosis at L5-S1. Treatment to date has included pain medication and physical therapy, which were noted to have failed to significantly relieve the pain. In a progress note dated 06-17-2015, the injured worker reported stabbing pain in the low back radiating to the bilateral lower extremities and tingling pain in the heels bilaterally along with increased pain in the legs after walking for more than 30 minutes. Pain was rated as 9 out of 10. Objective examination findings revealed tenderness to palpation of the thoracic and lumbar spine, decreased range of motion of the thoracic and lumbar spine, diminished sensation in the left L3 dermatome, 1 beat clonus on the right side and 3 beats on the left side, some discomfort with right-sided FABER maneuver, positive straight leg raise on the left and painful range of motion of the right knee. The physician noted that all treatment options were reviewed and that a transforaminal epidural steroid injection was recommended bilaterally at S1 for diagnostic and therapeutic purposes as the injured worker had failed conservative management and was hoping to avoid surgical intervention. On 07-29-2015, the injured worker continued to report stabbing low back pain rated as 8-9 out of 10. The injured worker reported pain was radiating to the bilateral hips and buttocks with occasional numbness in the buttocks after sitting more than 30 minutes and occasional numbness in the bilateral lower extremities

after standing for a long period of time. Objective findings were identical to findings on the 06-17-2015 visit with the exception that spasms were now documented in the thoracic and lumbar spine. Work status was documented as temporarily totally disabled. A request for authorization of bilateral lumbar transforaminal epidural steroid injection L5-S1 was submitted. There is no indication that any previous epidural steroid injections had been received. As per the 08-21-2015 utilization review, the request for bilateral lumbar transforaminal epidural steroid injection L5-S1 was non-certified.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Bilateral lumbar transforaminal epidural steroid injection L5-S1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** The patient presents on 07/29/15 with ongoing lower back pain which no longer radiates into the lower extremities, but still radiates into the buttocks and hips bilaterally. The patient also complains of associated occasional numbness in the buttocks and lower extremities. The patient's date of injury is 02/12/15. Patient has no documented surgical history directed at this complaint. The request is for bilateral lumbar transforaminal epidural steroid injection L5-S1. The RFA was not provided. Physical examination dated 07/29/15 reveals tenderness to palpation of the thoracic and lumbar spine with spasms noted, decreased sensation in the left L3 dermatomal distribution, positive straight leg raise test on the left side, and positive FABER maneuver. The patient is currently prescribed Norco, Soma, Diclofenac, and Orphenadrine. Diagnostic imaging included MRI of the lumbar spine dated 04/22/15, significant findings include: "L5-S1: Bulge asymmetric to the left at the level of the lateral recess with small lateral recess protrusion. Mild bilateral facet osteoarthritis, mild central canal and especially left lateral recess narrowing." Patient is currently classified as temporarily totally disabled. MTUS Guidelines, Epidural Steroid Injections section, page 46: "Criteria for the use of Epidural steroid injections: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3. Injections should be performed using fluoroscopy (live x-ray) for guidance. 8. Current research does not support a series of three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections." 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. In this case, the treater is requesting an initial lumbar ESI at the L5-S1 level for the management of this patient's chronic lower back pain with a radicular component. There is no evidence in the records provided that this patient has undergone any ESIs to date. Per progress note dated 07/29/15, the provider documents subjective leg symptoms in the buttocks and lower extremities, positive neurological findings of decreased sensation along the L3 dermatomal distribution, and positive straight leg raise test on the left. Diagnostic MRI

dated 04/22/15 only indicates disc bulge at L5-S1, a normal finding with no clear documentation of foraminal stenosis or nerve root abutment. The treater has requested bilateral L5-S1 injections, but there are no significant neurological pathologies at L4-5 or L5-S1 levels. This patient has radicular symptoms and exam findings consistent with compromise of the L3 level on the left side. Though it is not known why the provider is requesting a bilateral injection at the L5-S1 level, as there is no clear radiculopathy or neurological compromise consistent with foraminal stenosis or nerve root abutment on examination. Therefore, the request is not medically necessary.