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| <b>Case Number:</b>   | CM15-0194371 |                              |            |
| <b>Date Assigned:</b> | 10/08/2015   | <b>Date of Injury:</b>       | 10/05/2011 |
| <b>Decision Date:</b> | 11/20/2015   | <b>UR Denial Date:</b>       | 09/29/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/02/2015 |

### 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:

This is a 40 year old female with a date of injury of October 5, 2011. A review of the medical records indicates that the injured worker is undergoing treatment for spondylolisthesis, lower back pain, lumbar stenosis, degeneration of lumbar intervertebral disc, and displacement of lumbar intervertebral disc without myelopathy. Medical records dated May 8, 2015 indicate that the injured worker complained of ongoing symptoms of the low back and right leg, occasional slight numbness in the right leg, intermittent tingling in the leg and right rib, some weakness in the right leg, and occasional loss of balance. A progress note dated September 18, 2015 documented complaints of pain in the lower back with sneezing and coughing and ongoing right leg pain. Per the treating physician (September 18, 2015), the employee was temporarily totally disabled. The physical exam dated May 8, 2015 reveals tenderness to palpation of the midline back, tenderness of the right paraspinals, decreased range of motion of the lumbar spine with pain, and positive straight leg raise on the right. The progress note dated September 18, 2015 documented a physical examination that showed no changes since the examination performed on May 28, 2015. Treatment has included history of physical therapy that was not helpful, medications (Tramadol noted on September 18, 2015), computed tomography of the lumbar spine (April 20, 2015) that showed no significant changes compared to an magnetic resonance imaging dated November 15, 2011, with some small disc bulges at multiple levels in the lumbosacral spine that do not appear to be causing any significant stenosis or compression, and facet arthropathy at the L4-S1 facets, and magnetic resonance imaging of the lumbar spine (April 20, 2015) that showed mild discogenic disease at L3-4, L4-5 and L5-S1. The original utilization review (September 29, 2015) non-certified a request for lumbar epidural steroid injection at the right L5-S1 level.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **One (1) outpatient epidural steroid injection (ESI) at right L5-S1: Upheld**

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

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

**Decision rationale:** The patient presents on 09/18/15 with pain elicitation in the lower back upon sneezing and coughing, vaginal bleeding with prolonged ambulation, and right leg pain. The patient's date of injury is 10/05/11. The request is for one (1) outpatient epidural steroid injection (ESI) AT right L5-S1. The RFA is dated 09/23/15. Physical examination dated 09/18/15 reveals tenderness to palpation of the lumbar paraspinal musculature, intact sensation in the L1-S1 dermatomal distributions, and decreased sensation on the right medial calf to the top of the foot consistent with the L4 dermatomal distribution. The provider also notes positive straight leg raise test on the right. The patient is currently prescribed Tramadol. Diagnostic imaging included lumbar MRI dated 04/20/15, significant findings include: "L5-S1, there is 2-3 mm disc bulge indenting the epidural fat and abutting the ventral thecal sac and causing minimal lateral recess narrowing without any significant canal stenosis." 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 09/18/15, the provider documents subjective complaints of lower back pain which radiates into the right lower extremity. The physical examination findings of this progress note do include documentation of reduced sensation consistent with the L4 dermatomal distribution on the right, however the provider specifically indicates that the remaining dermatomes are neurologically intact - including the L5 and S1 distributions. Diagnostic MRI dated 04/20/15 notes a 2-3mm disc bulge at the requested levels with only minimal lateral recess narrowing - without evidence of canal stenosis or nerve root abutment. It is not clear why the provider would request a lumbar ESI at these levels given the lack of neurological compromise and mild disc bulge without nerve root abutment at L5-S1. MTUS guidelines require unequivocal physical examination findings

indicating neurological compromise in the dermatomal distribution associated with the request, corroborated by MRI evidence of foraminal stenosis/nerve root abutment. In this case, there is some evidence of neurological compromise, though not consistent with the dermatomal distributions of the levels requested, and only mild lateral recess narrowing with no nerve root abutment noted. Without clear documentation of neurological compromise at the requested levels corroborated by MRI imaging, the request cannot be substantiated. Therefore, the request is not medically necessary.