

<b>Case Number:</b>	CM15-0216119		
<b>Date Assigned:</b>	11/05/2015	<b>Date of Injury:</b>	09/25/2008
<b>Decision Date:</b>	12/23/2015	<b>UR Denial Date:</b>	10/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2015

### 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: Pennsylvania, Ohio, 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 50 year old male who sustained an industrial injury on 09-25-2008. A review of the medical records indicated that the injured worker is undergoing treatment for lumbar radiculopathy and lumbar degenerative disc disease. According to the treating physician's progress report on 09-21-2015, the injured worker continues to experience increased low back pain over the past month rated at 7 out of 10 with medications and 10 out of 10 on the pain scale without medications. Examination demonstrated an antalgic gait without the use of assistive devices. On palpation of the paravertebral muscles, bilateral hypertonicity, tenderness and trigger points were evident. Range of motion was restricted to 30 degrees flexion and 20 degrees extension due to pain. Lumbar facet loading and straight leg raise were positive on the left side. Faber test, distraction and thigh thrust were positive. Motor strength was decreased on the left lower extremity with sensation to light touch decreased over the anterior and lateral thigh on the left. Knee and ankle reflexes were 1 out of 4 bilaterally. According to the progress report on 09-21-2015, electrodiagnostic studies of the left lower extremity performed on 03-21-2014 was a normal study and a lumbar spine magnetic resonance imaging (MRI) performed in 2014 noted "L4-5 right paracentral protrusion with moderate right and mild left foraminal stenosis. Mild central canal and right lateral recess stenosis. Mild levoscoliosis of the lower lumbar spine with articulation of the left L5-S1 traverse process of the sacrum". Prior treatments have included diagnostic testing, chiropractic therapy, acupuncture therapy, physical therapy, transcutaneous electrical nerve stimulation (TENS) unit, left sacroiliac (SI) injection on 05-05-2015 with mild relief, transforaminal epidural steroid injection on 05-20-2014 (provided 50% pain relief,

duration of relief not documented) and medications. Current medications were listed as Norco and Gabapentin. Treatment plan consists of Functional Capacity Evaluation (FCE), diagnostic facet joint injection, continuing medication regimen, modified duty and the current request for left L4-5 transforaminal epidural steroid injection. On 10-29-2015, the Utilization Review determined the request for left L4-5 transforaminal epidural steroid injection was not medically necessary.

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

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

#### **Left lumbar 4-5 transforaminal epidural steroid injection: 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:** MTUS recommends an epidural steroid injection for treatment of a radiculopathy. This guideline supports such an injection only if there is documentation of a radiculopathy by physical examination corroborated by imaging studies and/or electrodiagnostic testing. The records in this case are equivocal in terms of such corroboration of a radiculopathy. Moreover, the records do not clearly document functional improvement from a prior ESI and do not clearly document the duration of that treatment. Most notably, MTUS generally recommends ESI treatment in the acute phase to facilitate early functional restoration; the records and guidelines do not document the probability of meaningful clinical benefit from an ESI in this chronic setting. For these multiple reasons, this request is not medically necessary.