

<b>Case Number:</b>	CM15-0089154		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	07/29/2008
<b>Decision Date:</b>	07/03/2015	<b>UR Denial Date:</b>	04/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### 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 68-year-old male, who sustained an industrial injury on 7/29/2008. The mechanism of injury is unknown. The injured worker was diagnosed as having lumbar radiculopathy, thoracic spine pain, lumbago, shoulder pain, elbow pain and lumbar facet syndrome/spondylosis. There is no record of a recent diagnostic study. Treatment to date has included radiofrequency ablation. In a progress note dated 3/24/2015, the injured worker complains of low back pain with radiation to the bilateral lower extremities. The pain is rated 3/10 at its best and 9/10 at its worst. The treating physician is requesting lumbar transforaminal epidural steroid injections to the right and left lumbar 5 and right and left sacral 1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar TESI Right L5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation Official disability guidelines, Low Back

- Lumbar & Thoracic (Acute & Chronic) Chapter states: "Epidural steroid injections (ESIs)", therapeutic.

**Decision rationale:** Based on the 03/24/15 progress report provided by treating physician, the patient presents with low back pain that radiates to the bilateral lower extremities to feet, rated 8/10. The request is for lumbar tesa right L5. RFA dated 04/03/15 provided. Patient's diagnosis on 02/24/15 and 03/24/15 included lumbar radiculopathy and lumbar facet syndrome/spondylosis. Physical examination to the lumbar spine on 03/24/15 revealed spasm and tenderness to palpation over the paravertebral muscles and the lumbar facets. Pain on flexion, extension and facet loading. Positive straight leg raise test bilaterally. Patient medications include Percocet, Atenolol, Quinapril, Tamsulosin, and Brintellix. Patient's work status not provided. Treatment reports were provided from 02/24/15 - 03/24/15. MTUS Chronic Pain Treatment Guidelines, section on "Epidural steroid injections (ESIs)" page 46 states these are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy." The MTUS Criteria for the use of Epidural steroid injections states: "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In addition, MTUS states that the patient must be "Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs and muscle relaxants.)" For repeat ESI, MTUS states, "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." ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter states: "Epidural steroid injections (ESIs), therapeutic: With discectomy: Epidural steroid administration during lumbar discectomy may reduce early neurologic impairment, pain, and convalescence and enhance recovery without increasing risks of complications. (Rasmussen, 2008) Not recommended post-op. The evidence for ESI for post lumbar surgery syndrome is poor. (Manchikanti, 2012)" Per 02/24/15 report, treater states, "I am recommending lumbar transforaminal epidural steroid injection at bilateral L5-S1 for diagnostic purposes. I have discussed the rationale for the recommended injection, including goals of pain relief and improved function." There is no indication patient had prior lumbar spine ESI. Per 03/24/15 report, EMG/NCV study dated 12/2013 revealed "mild chronic denervation and reinnervation in the muscles innervated by the L5 and S1 roots on the right. There is no evidence of acute lumbosacral radiculopathy or myopathy on EMG examination at this time." Per 03/24/15 report, MRI of the lumbar spine dated 08/09/13 showed "at L5-S1 there is bilateral facet arthropathy. There is a 5 mm LEFT posterior lateral disc protrusion extending into the LEFT neuroforamen." Per 03/24/15 report, MRI of the lumbar spine dated 07/2014 revealed "at L5-S1 there is mild degenerative disc space narrowing. There is a moderate-sized focal disc protrusion within the RIGHT neural foramen. No nerve root compression or displacement is identified. No spinal stenosis." In this case, treater has documented radiculopathy, and supported with positive findings on physical examination. However, EMG and MRI do not corroborate with patient's radicular symptoms, stating "There is no evidence of acute lumbosacral radiculopathy," and "No spinal stenosis." MTUS requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. This request does not meet guideline criteria for the procedure. Therefore, the request is not medically necessary.

## **Lumbar TESI Left L5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation Official disability guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter states: "Epidural steroid injections (ESIs)", therapeutic.

**Decision rationale:** Based on the 03/24/15 progress report provided by treating physician, the patient presents with low back pain that radiates to the bilateral lower extremities to feet, rated 8/10. The request is for lumbar TESI left L5. RFA dated 04/03/15 provided. Patient's diagnosis on 02/24/15 and 03/24/15 included lumbar radiculopathy and lumbar facet syndrome/spondylosis. Physical examination to the lumbar spine on 03/24/15 revealed spasm and tenderness to palpation over the paravertebral muscles and the lumbar facets. Pain on flexion, extension and facet loading. Positive straight leg raise test bilaterally. Patient medications include Percocet, Atenolol, Quinapril, Tamsulosin, and Brintellix. Patient's work status not provided. Treatment reports were provided from 02/24/15 - 03/24/15. MTUS Chronic Pain Treatment Guidelines, section on "Epidural steroid injections (ESIs)" page 46 states these are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." The MTUS Criteria for the use of Epidural steroid injections states: "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In addition, MTUS states that the patient must be "Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs and muscle relaxants.)" For repeat ESI, MTUS states, "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." ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter states: "Epidural steroid injections (ESIs), therapeutic: With discectomy: Epidural steroid administration during lumbar discectomy may reduce early neurologic impairment, pain, and convalescence and enhance recovery without increasing risks of complications. (Rasmussen, 2008) Not recommended post-op. The evidence for ESI for post lumbar surgery syndrome is poor. (Manchikanti, 2012)" Per 02/24/15 report, treater states, "I am recommending lumbar transforaminal epidural steroid injection at bilateral L5-S1 for diagnostic purposes. I have discussed the rationale for the recommended injection, including goals of pain relief and improved function." There is no indication patient had prior lumbar spine ESI. Per 03/24/15 report, EMG/NCV study dated 12/2013 revealed "mild chronic denervation and reinnervation in the muscles innervated by the L5 and S1 roots on the right. There is no evidence of acute lumbosacral radiculopathy or myopathy on EMG examination at this time." Per 03/24/15 report, MRI of the lumbar spine dated 08/09/13 showed "at L5-S1 there is bilateral facet arthropathy. There is a 5 mm LEFT posterior lateral disc protrusion extending into the LEFT neuroforamen." Per 03/24/15 report, MRI of the lumbar spine dated 07/2014 revealed "at L5-S1 there is mild degenerative disc space narrowing. There is a moderate-sized focal disc protrusion within the

RIGHT neural foramen. No nerve root compression or displacement is identified. No spinal stenosis." In this case, treater has documented radiculopathy, and supported with positive findings on physical examination. However, EMG and MRI do not corroborate with patient's radicular symptoms, stating, "There is no evidence of acute lumbosacral radiculopathy," and "No spinal stenosis." MTUS requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. This request does not meet guideline criteria for the procedure. Therefore, the request is not medically necessary.

### **Lumbar TESI Right S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation Official disability guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter states: "Epidural steroid injections (ESIs)", therapeutic.

**Decision rationale:** Based on the 03/24/15 progress report provided by treating physician, the patient presents with low back pain that radiates to the bilateral lower extremities to feet, rated 8/10. The request is for lumbar TESI right S1. RFA dated 04/03/15 provided. Patient's diagnosis on 02/24/15 and 03/24/15 included lumbar radiculopathy and lumbar facet syndrome/spondylosis. Physical examination to the lumbar spine on 03/24/15 revealed spasm and tenderness to palpation over the paravertebral muscles and the lumbar facets. Pain on flexion, extension and facet loading. Positive straight leg raise test bilaterally. Patient medications include Percocet, Atenolol, Quinapril, Tamsulosin, and Brintellix. Patient's work status not provided. Treatment reports were provided from 02/24/15 - 03/24/15. MTUS Chronic Pain Treatment Guidelines, section on "Epidural steroid injections (ESIs)" page 46 states these are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." The MTUS Criteria for the use of Epidural steroid injections states: "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In addition, MTUS states that the patient must be "Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs and muscle relaxants.)" For repeat ESI, MTUS states, "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." ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter states: "Epidural steroid injections (ESIs), therapeutic: With discectomy: Epidural steroid administration during lumbar discectomy may reduce early neurologic impairment, pain, and convalescence and enhance recovery without increasing risks of complications. (Rasmussen, 2008) Not recommended post-op. The evidence for ESI for post lumbar surgery syndrome is poor. (Manchikanti, 2012)" Per 02/24/15 report, treater states, "I am recommending lumbar transforaminal epidural steroid injection at bilateral L5-S1 for diagnostic purposes. I have discussed the rationale for the recommended injection, including goals of pain relief and improved

function." There is no indication patient had prior lumbar spine ESI. Per 03/24/15 report, EMG/NCV study dated 12/2013 revealed "mild chronic denervation and reinnervation in the muscles innervated by the L5 and S1 roots on the right. There is no evidence of acute lumbosacral radiculopathy or myopathy on EMG examination at this time." Per 03/24/15 report, MRI of the lumbar spine dated 08/09/13 showed "at L5-S1 there is bilateral facet arthropathy. There is a 5 mm LEFT posterior lateral disc protrusion extending into the LEFT neuroforamen." Per 03/24/15 report, MRI of the lumbar spine dated 07/2014 revealed "at L5-S1 there is mild degenerative disc space narrowing. There is a moderate-sized focal disc protrusion within the RIGHT neural foramen. No nerve root compression or displacement is identified. No spinal stenosis." In this case, treater has documented radiculopathy, and supported with positive findings on physical examination. However, EMG and MRI do not corroborate with patient's radicular symptoms, stating, "There is no evidence of acute lumbosacral radiculopathy," and "No spinal stenosis." MTUS requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. This request does not meet guideline criteria for the procedure. Therefore, the request is not medically necessary.

### **Lumbar TESI Left S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation Official disability guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter states: "Epidural steroid injections (ESIs)", therapeutic.

**Decision rationale:** Based on the 03/24/15 progress report provided by treating physician, the patient presents with low back pain that radiates to the bilateral lower extremities to feet, rated 8/10. The request is for lumbar TESI left S1. RFA dated 04/03/15 provided. Patient's diagnosis on 02/24/15 and 03/24/15 included lumbar radiculopathy and lumbar facet syndrome/spondylosis. Physical examination to the lumbar spine on 03/24/15 revealed spasm and tenderness to palpation over the paravertebral muscles and the lumbar facets. Pain on flexion, extension and facet loading. Positive straight leg raise test bilaterally. Patient medications include Percocet, Atenolol, Quinapril, Tamsulosin, and Brintellix. Patient's work status not provided. Treatment reports were provided from 02/24/15 - 03/24/15. MTUS Chronic Pain Treatment Guidelines, section on "Epidural steroid injections (ESIs)" page 46 states these are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." The MTUS Criteria for the use of Epidural steroid injections states: "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In addition, MTUS states that the patient must be "Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs and muscle relaxants.)" For repeat ESI, MTUS states, "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." ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter states: "Epidural steroid injections (ESIs), therapeutic: With discectomy: Epidural steroid administration during lumbar discectomy may reduce early neurologic impairment, pain, and convalescence and enhance recovery without increasing risks of complications. (Rasmussen, 2008) Not recommended post-op. The evidence for ESI for post lumbar surgery syndrome is poor. (Manchikanti, 2012)" Per 02/24/15 report, treater states, "I am recommending lumbar transforaminal epidural steroid injection at bilateral L5-S1 for diagnostic purposes. I have discussed the rationale for the recommended injection, including goals of pain relief and improved function." There is no indication patient had prior lumbar spine ESI. Per 03/24/15 report, EMG/NCV study dated 12/2013 revealed "mild chronic denervation and reinnervation in the muscles innervated by the L5 and S1 roots on the right. There is no evidence of acute lumbosacral radiculopathy or myopathy on EMG examination at this time." Per 03/24/15 report, MRI of the lumbar spine dated 08/09/13 showed "at L5-S1 there is bilateral facet arthropathy. There is a 5 mm left posterior lateral disc protrusion extending into the left neuroforamen." Per 03/24/15 report, MRI of the lumbar spine dated 07/2014 revealed "at L5-S1 there is mild degenerative disc space narrowing. There is a moderate-sized focal disc protrusion within the RIGHT neural foramen. No nerve root compression or displacement is identified. No spinal stenosis." In this case, treater has documented radiculopathy, and supported with positive findings on physical examination. However, EMG and MRI do not corroborate with patient's radicular symptoms, stating, "There is no evidence of acute lumbosacral radiculopathy," and "No spinal stenosis." MTUS requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. This request does not meet guideline criteria for the procedure. Therefore, the request is not medically necessary.