

<b>Case Number:</b>	CM14-0111990		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	07/05/2000
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	06/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/18/2014

### 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. The expert reviewer is Board Certified in Emergency Medicine and Fellowship in Emergency Medical Services and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 61 year old male who reported an injury on 07/05/2000. The mechanism of injury was not specified. His diagnoses included failed low back pain syndrome status post L4-5 and L5-S1 lumbar fusion, lumbar radiculopathy, chronic low back pain, and depression. His previous treatments included a right L2-3, L5-S1 transforaminal epidural steroid injection done on 03/26/2013 and 10/4/2013, chiropractic visits, and transcutaneous electrical nerve stimulator. He had an MRI of the lumbar spine on 06/05/2008 which showed L3-4 degenerative disc disease and facet osteoarthritis, mild spinal stenosis, L4-5 laminectomy and discectomy, L5-S1 minimal bulge, and right L5 nerve encase with scarring tissue. On 12/16/2013, he reported his back pain at 7/10. It was noted he had 30% pain relief from the epidural steroid injection for 3 weeks and felt the "effects of the epidural had worn off". On 06/14/2014 the injured worker reported increased right lower extremity pain and described it as sciatica. He stated his pain at the time was 7/10 with medications. The injured worker reported the transforaminal epidural steroid injection on 10/04/2013 was greatly beneficial with 70% pain relief which lasted for at least 10 weeks. It allowed him to better function, complete activities of daily living, and reduce his medications. Physical examination findings included hypoesthesia and dysesthesia to the posterior and anterior right thigh and calves. The injured worker was noted to have intermittent decreased sensation to touch on the lower right leg and a positive straight leg raise. His medications included Plavix, Norco, Methadone, Flexeril, Lyrica, Cymbalta, Lidoderm patches, Temazepam, Prozac, and Colace. The treatment plan included a repeat right transforaminal epidural steroid injection at L2-3 and L5-S1. The rationale for the request was he had "great benefit" from the injection on 10/04/2013. The request for authorization form was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Transforaminal ESI L2-3 & L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** Based on the clinical information submitted for review, the request for Right Transforaminal epidural steroid injections L2-3 & L5-S1 is not medically necessary. As stated in California MTUS Guidelines, epidural steroid injections are recommended as an option for treatment of radicular pain. 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. They recommend no more than 2 epidural steroid injections. The injured worker reported low back pain. He received epidural steroid injections on 03/26/2013 and 10/04/2013 and reported that the medication helped him with pain relief and he was able to better function, complete activities of daily living, and take less medication. His physical examination on 06/14/2014 indicated he had hypoesthesia and dysesthesia to the posterior and anterior right thigh and calves. Also, he had tingling burning pain constant in his right foot and toes, intermittent decreased sensation to touch on lower right leg, and a positive straight leg raise. His MRI of the lumbar spine from 06/05/2008 showed L5-S1 minimal bulge and right L5 nerve encase with scarring tissue. It was noted that the injured worker has had 2 epidural steroid injections and the guidelines do not recommend more than 2 epidural steroid injections. Furthermore, the clinical documentation showed conflicting pain relief percentages from the epidural steroid injection. The injured worker reported on 12/16/2013 and 01/13/2014 that he received 30% pain improvement; however, the note from 06/14/2014 showed he had 70% pain relief with the ability to decrease pain medications and improve overall function. The guidelines indicate there should be at least 50% pain relief with associated reduction of pain medication use for 6-8 weeks. As such, the request for Right Transforaminal epidural steroid injections L2-3 & L5-S1 is not medically necessary.