

<b>Case Number:</b>	CM14-0142096		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	02/04/1992
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	08/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/02/2014

### 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 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 62 year old male with a reported injury on 02/04/1992. The mechanism of injury was repetitive lifting. The injured worker's diagnoses included cervical spine sprain/strain syndrome with right upper extremity radiculopathy, right shoulder impingement syndrome, lumbar post-laminectomy syndrome, bilateral lower extremity radiculopathy, reactionary depression/anxiety, medication induced gastritis, medication induced constipation, gastro esophageal reflux disease, morbid obesity, bilateral carpal tunnel syndrome, right knee internal derangement, and erectile dysfunction secondary to bilateral lower extremity radiculopathy. The injured worker's past treatments included medications, physical therapy, lumbar and cervical epidural steroid injections, and a home exercise plan. The injured worker's diagnostic testing included cervical spine MRIs on 12/16/2005, 05/13/2010, and 01/16/2012, upper extremity EMG studies on 11/17/2006, 12/15/1995, and 12/08/2009, and a right knee MRI on 03/06/2012. He also had a lumbar spine MRI on 03/18/2007 which revealed a 3-4 mm disc bulge with annular fissure at L3-4, a 6-7 mm disc bulge at L4-5, and a 4-5 mm disc bulge at L5-S1, and compression on the exiting nerve roots and traversing nerve roots at L4-5 and L5-S1. Another lumbar spine MRI on 11/18/2009 revealed a 5-6 mm posterior disc protrusion with moderate to severe hypertrophic facet changes and lateral recess stenosis bilaterally at L4-5, 3-4 mm disc protrusions at L5-S1 and L3-4 with hypertrophic facet changes right greater than left at L5-S1. A third lumbar spine weight bearing MRI on 01/16/2012 revealed significant disc desiccation and straightening of the normal lordosis, 5 mm disc protrusions at L3-4, L4-5, and L5-S1 with a right paracentral disc protrusion at L5-S1 and a grade I spondylolisthesis at L4-5, moderate facet hypertrophy with bilateral neural foraminal narrowing, annular tears were noted at L3-4, L4-5, and L5-S1, and at L2-3 there was an annular tear, a 2-3 mm bulge and facet hypertrophy. The injured worker's surgical history included laminectomy at L3-S1. The injured

worker was evaluated for low back pain rated as 5-6/10 on 08/05/2014. The clinician observed and reported that the injured worker had a lumbar epidural steroid injection on 03/31/2014 which provided at least 60% pain relief to his lower back and radicular symptoms to his lower extremities, the effects of which lasted three months. The injured worker was able to sit and stand for longer periods of time enabling him to perform simple chores around the home with less pain. The focused lumbar examination revealed tenderness to palpation to the posterior bilateral musculature with increased muscle rigidity. There were numerous trigger points which were palpable and tender throughout the lumbar paraspinal muscles. The lumbar range of motion was decreased as the injured worker was only able to bend forward until his outstretched fingers reached his knees and extension was limited at 10 degrees. Both flexion and extension caused pain. The straight leg raise was positive bilaterally at about 45 degrees which caused radicular symptoms. There was decreased sensation along the posterior lateral thigh and posterior lateral calf bilaterally at approximately the L5-S1 distribution. The treatment plan was to proceed with a fluoroscopically guided transforaminal epidural steroid injection at bilateral L5-S1. The injured worker's medications included Norco 10/325 mg, Neurontin 600 mg, Ambien CR, FexMid 7.5 mg, Prilosec, Anaprox, Wellbutrin XL, Cialis, Migrainal nasal spray, Protonix, LidoPro topical, and AndroGel. Section 9: The request was for 1 Transforaminal lumbar epidural steroid injection at the levels of the bilateral L5-S1 under fluoroscopic guidance for pain control and helps restore range of motion. The request for authorization form was not provided.

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

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

#### **1 Transforaminal lumbar epidural steroid injection at the levels of the bilateral L5-S1 under fluoroscopic guidance: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

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

**Decision rationale:** The request for 1 Transforaminal lumbar epidural steroid injection at the levels of the bilateral L5-S1 under fluoroscopic guidance is not medically necessary. The injured worker complained of low back pain. The California MTUS Chronic Pain Guidelines recommend epidural steroid injection as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). 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. The provided documentation did not indicate the injured worker had at least 50% pain relief with associated reduction of medication use and significant objective functional improvement for six to eight weeks following the lumbar epidural steroid injection on 03/31/2014. Therefore, the request for 1 Transforaminal lumbar epidural steroid injection at the levels of the bilateral L5-S1 under fluoroscopic guidance is not medically necessary.