

<b>Case Number:</b>	CM14-0213559		
<b>Date Assigned:</b>	12/31/2014	<b>Date of Injury:</b>	01/04/2011
<b>Decision Date:</b>	02/27/2015	<b>UR Denial Date:</b>	11/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/22/2014

### 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. 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: Tennessee, Mississippi

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 patient is a 63-year-old male who has submitted a claim for L5-S1 spondylolisthesis, lumbar disc herniation, right radiculopathy, L2-L3, L3-L4 and L4-L5 disc disease, sciatica and lumbosacral sprain / strain associated with an industrial injury date of 1/4/2011. Medical records from 2014 were reviewed. The patient complained of low back pain radiating to the lower extremities associated with numbness and tingling sensation. Physical examination showed tenderness and limited motion of the lumbar spine, good strength of extensor hallucis longus, diminished sensation over the lateral left thigh, and antalgic gait. The electrodiagnostic study of bilateral lower extremities from 7/29/2014 revealed moderate-to-severe left L5 and S1 lumbosacral radiculopathy and moderate right S1 lumbar radiculopathy. There was mild-to-moderate sensory peripheral neuropathy involving the bilateral lower extremities in an asymmetric pattern. The MRI of the lumbar spine, dated 7/25/2012, demonstrated a grade I spondylolisthesis at L5-S1 associated with bilateral L5 spondylosis with moderate-to-marked cephalocaudad narrowing of the L6 neural foramina bilaterally. Treatment to date has included lumbar epidural steroid injection (ESI) on 2/15/2013 (resulting to 40%-50% relief), repeat ESI on 3/25/2014 (resulting to 50% pain relief), physical therapy and medications. The utilization review from 11/22/2014 denied the request for lumbar spine transforaminal epidural steroid injection right L5-S1 level because of no evidence of reduced medication use and increased function to support a repeat block.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar spine transforaminal epidural steroid injection right L5-S1 level:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26, Epidural Steroid Injection Page(s): 46.

**Decision rationale:** As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. In this case, the patient complained of low back pain radiating to the lower extremities associated with numbness and tingling sensation. Physical examination showed tenderness and limited motion of the lumbar spine, good strength of extensor hallucis longus, diminished sensation over the lateral left thigh, and antalgic gait. The electrodiagnostic study of bilateral lower extremities from 7/29/2014 revealed moderate-to-severe left L5 and S1 lumbosacral radiculopathy and moderate right S1 lumbar radiculopathy. There was mild-to-moderate sensory peripheral neuropathy involving the bilateral lower extremities in an asymmetric pattern. The MRI of the lumbar spine, dated 7/25/2012, demonstrated a grade I spondylolisthesis at L5-S1 associated with bilateral L5 spondylosis with moderate-to-marked cephalocaudad narrowing of the L6 neural foramina bilaterally. The patient underwent lumbar epidural steroid injection (ESI) on 2/15/2013 resulting to 40%-50% relief and a repeat ESI on 3/25/2014 (resulting to 50% pain relief). However, there is no documentation concerning functional improvement and decreased medication usage to warrant a repeat ESI. The guideline criterion for repeat ESI has not been met. Therefore, the request for lumbar spine transforaminal epidural steroid injection right L5-S1 level is not medically necessary.