

<b>Case Number:</b>	CM14-0215852		
<b>Date Assigned:</b>	01/05/2015	<b>Date of Injury:</b>	06/23/2003
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### 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: 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:

This 60 year old male sustained an industrial related injury on 06/23/2003. The results of the injury included a sudden onset of pain. The initial diagnoses and specifics of the injury was not provided or discussed. Per the progress report (PR) (11/06/2014), the injured worker's subjective complaints included left low back pain, and pain in the sacroiliac region which was described as aching and throbbing with moderate severity. The pain radiated to the left thigh and left calf. Other complaints included back stiffness and decreased range of motion (ROM) in the spine. Complaints were exacerbated by bending, lifting and twisting. Objective findings on this report included painful decreased flexion of the lumbosacral spine, restricted and painful extension, positive straight leg raises, significant and persistent pain in the left leg, and a antalgic gait. An exam by the pain specialist (11/25/2014) stated that the injured worker reported that the severity of his pain was rated as a 6/10 but as severe as 10/10 at its worst. 70% of his pain was located in the lumbosacral spine (left), and 30% was located in the left lower extremity. The injured worker described his pain as stabbing and knife-like sensation to the sacral sulcus, posterior thigh and calf with pins and needles and numbness. There were no objective findings or testing noted during this exam, nor during the previous exam dated 10/15/2014. Treatment to date has included medications, modified activities, and a previous lumbar epidural steroid injection (ESI). Diagnostic testing was not provided in the clinical notes submitted; however, the UR mentioned a previous MRI of the lumbar spine (dated 04/30/2010) which was reported to have revealed multilevel degenerative disc changes with facet joint hypertrophy and neural foraminal narrowing of the L3-L4 and L5-S1 levels. Current diagnoses include lumbar disc herniation,

herniation of lumbar disc with radiculopathy, lumbar spine pain, degenerative spondylolisthesis, disc degeneration with narrowing, lumbar radiculopathy, disc disorder with radiculopathy, and neuroforaminal stenosis. The lumbar ESI, transforaminal L5 & S1, was requested for the treatment of lumbar pain and radiculopathy. Treatments in place around the time the lumbar ESI was requested included activity restrictions and medications. The injured worker reported pain was increased. Functional deficits and activities of daily living were not addressed and there was insufficient documentation to support any changes. Work status was unchanged as the injured worker was returned to work on modified restrictions. Dependency on medical care was unchanged. On 12/11/2014, Utilization Review non-certified a prescription for a lumbar ESI, transforaminal L5 & S1 which was requested on 12/08/2014. The lumbar ESI was non-certified based on insufficient evidence of objective improvements from previous injections which should include a reduction in medications, and lack of documentation of a formal plan of active rehabilitation such as physical therapy or home exercise program in conjunction with the ESI. The MTUS Chronic Pain guidelines were cited. This UR decision was appealed for an Independent Medical Review. The submitted application for Independent Medical Review (IMR) requested an appeal for the non-certification of lumbar ESI, transforaminal L5 & S1.

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

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

#### **Lumbar epidural steroid injection, transforaminal at left 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): 46-47.

**Decision rationale:** The patient presents with left low back pain, rated 06/10, radiating to left buttock, left thigh, and left calf. Associated symptoms include paresthesias and decreased spine range of motion: flexion 60 degrees with pain and extension 10 degrees with pain. Patient's diagnosis on 11/25/14 included lumbar spine pain, spondylolisthesis, degenerative, disc degeneration, narrowing, lumbar, lumbar radiculopathy, disc disorder with radiculopathy, and neuroforaminal stenosis. The patient is to return to modified duty. Of note, patient is status-post ESI with reported 80% improvement in pain, per the report dated 10/15/14. MTUS page 46, 47 states that an ESI is recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). MTUS further states, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. Per progress report dated 11/25/14, treater states that the request of ESI on the left at L5 and S1 is for treatment of diagnosed neuroforaminal narrowing, radiculopathy, and spondylolisthesis. However, there are no imaging studies, and exam findings that support the diagnosis of radiculopathy. The patient had a prior ESI with 80% reported reduction of pain but the duration of relief and any associated

functional improvement including medication reduction are not documented. The request is not medically necessary.