

<b>Case Number:</b>	CM15-0165567		
<b>Date Assigned:</b>	09/29/2015	<b>Date of Injury:</b>	06/24/1998
<b>Decision Date:</b>	11/16/2015	<b>UR Denial Date:</b>	08/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/24/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 injured worker is a 56 year old male, who sustained an industrial injury on 6-24-1998. The medical records submitted for this review did not include documentation regarding the initial injury. Diagnoses include lumbar radiculitis, left hip pain, left knee pain, anxiety, depression, chronic pain, and status post knee surgery, status post left tibia ORIF. Treatments to date include activity modification, medication therapy, chiropractic therapy, psychotherapy, TENS unit, and lumbar epidural steroid injection. Currently, he complained of ongoing low back pain with radiation down the left lower extremity associated with weakness, numbness, and tingling. Pain was reported 5 out of 10 VAS with medication and 7 out of 10 VAS without medication. The medical records documented report of increased worsening of left leg pain and numbness. On 7-6-15, the physical examination documented tenderness of lumbar region with muscle spasm noted in L4-5 and bilateral L4-S1. There was decreased range of motion, and no changes in sensory exam from prior visits. The provider documented a previous therapeutic lumbar epidural steroid injection had a "positive response". The plan of care included a repeat lumbar epidural steroid injection to L4-5 and L5-S1. This appeal review will address the authorization request for one left L4 and S1 transforaminal epidural under fluoroscopy. The Utilization Review dated 8-5-15, denied the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **1 Left L4 and S1 transoframinal epidural under fluoroscopy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** The claimant has a remote history of a work injury in June 1999 and is being treated for chronic pain including low back pain with left lower extremity radiating symptoms. An MRI of the lumbar spine in June 2012 showed findings of multilevel disc bulging without lateralization and with mild foraminal and canal stenosis. Electrodiagnostic testing in April 2013 was negative for radiculopathy. When seen, pain was rated at 5-7/10 and had worsened. He was having left lower extremity pain with weakness, numbness, and tingling. Physical examination findings included lumbar spasms with tenderness. There was decreased and painful range of motion. There was lower extremity edema and left calf tenderness was noted. The motor and sensory examination were reported as unchanged from the prior examination with the same notation carried through the records that were provided for review so that no actual motor or sensory examination is documented. Criteria for the use of epidural steroid injections include radicular pain, defined as pain in dermatomal distribution with findings of radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, there are no physical examination findings such as decreased strength or sensation in a myotomal or dermatomal pattern or asymmetric reflex response that support a diagnosis of radiculopathy. There are no left lateralized findings or any reported neural compromise that would support a diagnosis of left lower extremity radiculopathy. The requested epidural steroid injection is not considered medically necessary.

## **Voltaren gel 1% #3: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation ODG Workers' Compensation Drug Formulary.

**Decision rationale:** The claimant has a remote history of a work injury in June 1999 and is being treated for chronic pain including low back pain with left lower extremity radiating symptoms. An MRI of the lumbar spine in June 2012 showed findings of multilevel disc bulging without lateralization and with mild foraminal and canal stenosis. Electrodiagnostic testing in April 2013 was negative for radiculopathy. When seen, pain was rated at 5-7/10 and had worsened. He was having left lower extremity pain with weakness, numbness, and tingling. Physical examination findings included lumbar spasms with tenderness. There was decreased and painful range of motion. There was lower extremity edema and left calf tenderness was noted. The motor and sensory examination were reported as unchanged from the prior

examination with the same notation carried through the records that were provided for review so that no actual motor or sensory examination is documented. Topical non-steroidal anti-inflammatory medication can be recommended for patients with chronic pain where the target tissue is located superficially in patients who either do not tolerate, or have relative contraindications, for oral non-steroidal anti-inflammatory medications. In this case, there is no apparent history of intolerance or contraindication to an oral NSAID. Voltaren gel is not an ODG formulary first-line medication. The request is not considered medically necessary.