

<b>Case Number:</b>	CM13-0033986		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	04/08/2012
<b>Decision Date:</b>	02/19/2014	<b>UR Denial Date:</b>	09/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/11/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. 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 physician 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 35 year old female with a date of injury of April 8, 2012. The patient has low back pain which radiates into the lower extremities. The original mechanism of injury was stooping over to lift an objects. The requesting healthcare provider has documented on physical examination that the patient has tenderness in the lumbar region with palpation. Motor testing of the lower extremities reveals five of five strength. Sensation was intact to light touch in pinprick. The Achilles deep tendon reflex was noted to be diminished. Straight leg raise was negative bilaterally. Lumbar MRI performed on date of service June 28, 2012 demonstrates this degeneration and narrowing at L4-5, L5-S1 with Modic type fibrovascular changes at the endplates. At L4-5, there is a 3 mm disc protrusion with 1 cm downward extension to the right with moderate lateral recess stenosis and right L5 nerve root impingement. At L5 - S1 there is a 5 to 6 mm right greater than left disc protrusion with moderately severe right greater than left neuroforaminal stenosis. Posteriorly, the disc abuts the traversing S1 nerves in the mildly stenotic central canal. The disputed issue is a request for bilateral L4-5, L5-S1 transforaminal epidural steroid injection. A utilization review decision had denied this since "the outcome of prior conservative treatment interventions was not specified in the record review." The utilization reviewer pointed out that the total number of sessions of physical therapy and acupuncture are not known, as well as the outcomes of these treatment approaches was not specified

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral L4-L5 and L5-S1 transforaminal epidural injection with fluoroscopy: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 47.

**Decision rationale:** The California Medical Treatment and Utilization Schedule specifies on page 47 of the Chronic Pain Medical Treatment Guidelines the following regarding Epidural steroid injections (ESIs) "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three." Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) 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.