

<b>Case Number:</b>	CM13-0044825		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	09/03/2012
<b>Decision Date:</b>	12/02/2014	<b>UR Denial Date:</b>	10/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine 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 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 43 year old female with an original date of injury on 9/30/2010. The patient sustained a left knee injury as she pivoted while removing clothing from a washing machine. It is noted that a utilization review indicated the date of injury was 9/3/2012; however, upon further review of provided documentation this appears to not have been the timing of the original injury. The patient's industrially related diagnoses include lumbago, displacement of lumbar intervertebral disc without myelopathy, unspecific internal derangement of the knee. The patient has had multiple knee arthroscopic surgeries dating from 2/2011 to 5/2012. A MRI of lumbar spine of unknown date showed L4-5 disc herniation, spinal canal compromise, bilateral neural foraminal narrowing, facet arthropathy. The patient was taking glucosamine / chondroitin, Dendracin lotion, NSAIDs, tramadol, and cyclobenzaprine with moderate relief of her pain. The patient also has undergone 12 sessions of physical therapy without significant relief of her pain. The disputed issue is for a L4-5 epidural steroid injection. A utilization review determination on 10/2/2013 had noncertified this request. The stated rationale for the denial was the provided documentation failed to meet the evidence based guidelines. The utilization review indicated the following information was missing from the provided documentation, including the mechanism of injury, medications, other conservative therapies, surgical history, and diagnostic studies. In addition, the MRI report which indicated L4-5 disc herniation was not provided for review. Therefore, the request was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **L4-5 EPIDURAL STEROID INJECTION:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007). 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections." The utilization review indicated the following information was missing from the provided documentation, including the mechanism of injury, medications, other conservative therapies, surgical history, and diagnostic studies. Based on a note from 9/11/2013, patient has numbness, tingling, and weakness of the left leg.

The physical exam finding on the same date shows positive diminished sensation in the left L4-5 dermatomes of the lower extremities. A progress note from 8/14/2013 documents bilateral reduced lower extremity reflexes at 1+ / 4. Another progress note dating on 7/23/2013 notes a MRI of the lumbar spine was performed. The MRI findings were documented in multiple progress notes stating L4-5 disc herniation, spinal canal compromise, bilateral neural foraminal narrowing, facet arthropathy. The patient has tried other conservative treatment such as medications and physical therapy without significant improvement of her pain. Given the documentation of radiculopathy on exam, correlation of symptoms with imaging study, and the failure of conservative treatments, the request for lumbar epidural steroid injection is indicated at this time. This request is medically necessary.