

<b>Case Number:</b>	CM13-0060584		
<b>Date Assigned:</b>	06/09/2014	<b>Date of Injury:</b>	04/15/2013
<b>Decision Date:</b>	07/14/2014	<b>UR Denial Date:</b>	11/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2013

### 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 New Jersey and is licensed to practice in Family Medicine. 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 claimant is a 56 year old female who was injured on 4/15/13. She developed right shoulder and back pain following the injury. The claimant was later diagnosed with lumbar discogenic myofascial pain, bilateral lumbar radicular syndrome, disc protrusion with annular tear L4-L5 and disc bulge L3-L4 and L5-S1 (based on MRI from 6/20/13), mild degenerative disc and joint disease of the lumbar spine, lumbar spine dysfunction, and right shoulder strain with underlying calcific tendinitis. She was treated with NSAIDS, physical therapy which was helping her significantly. MRI done on 6/20/13 showed L2-L3, L3-L4, and L4-L5 disc desiccation with diffuse annular bulges with indentation of the thecal sac, and minimal displacement of the exiting L5 nerves, which are not compressed. There is also arthropathy with mild neural foraminal stenosis at each level. L5-S1 minimal disc desiccation posterior annular bulge was seen, but there was no disc herniation or central canal stenosis. On 10/10/13 and 10/31/13 the claimant was seen by her pain management doctor complaining of her stabbing pain in her lower back which radiated to her bilateral buttocks and into the knees (7/10 pain scale), with walking and bending aggravating these symptoms. She reported her medications had been helping with the pain, however. The physical examination for both those days were similar with her gait being normal on the toes and heels, range of motion of the lumbar spine was restricted, and tenderness was exhibited with palpation of the lower back, as well as a straight leg raise test was positive with radicular pain in the L4 distribution, but without any sensory abnormalities with touch and pinprick testing of the lower extremities. On 10/10/13 (and again on 10/31/13) she was then recommended she continue her oral medications and requested she have an epidural injection for the bilateral L4 level.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EPIDURAL STEROID INJECTION BILATERAL L4:** Overturned

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

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

**Decision rationale:** The MTUS Guidelines state that epidural steroid injections are recommended as an option for treatment of lumbar radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) and can offer short term pain relief, but use should be in conjunction with other rehab efforts, including continuing a home exercise program. The criteria as stated in the MTUS Guidelines for epidural steroid injection use for chronic pain includes the following: 1. radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, 2. Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs, and muscle relaxants), 3. Njections should be performed using fluoroscopy 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, and 8. Current research does not support "series-of-three" injections in either the diagnostic or therapeutic phase, and instead only up to 2 injections are recommended. In this case, the MRI and physical findings of the treating physician give enough evidence of some nerve impingement causing her symptoms, although the findings on MRI are not severe. Due to the claimant not having responded to conservative treatments, the claimant warrants at least a diagnostic trial injection so see if she responds and is able to increase her function and reduce her pain. Therefore, the request for an epidural steroid injection of the Bilateral L4 is medically necessary and appropriate.