

<b>Case Number:</b>	CM14-0115354		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	10/14/2008
<b>Decision Date:</b>	11/18/2014	<b>UR Denial Date:</b>	07/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2014

### 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. The expert reviewer is Board Certified in Occupational 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:

Injured worker is a male with date of injury 10/14/2008. Per secondary treating physician's progress report dated 4/9/2014, the injured worker complains of low back pain and neck pain. He continues to have pain rated at 7/10. On examination of the lumbar spine there is spasm, painful range of motion as well as limited range of motion. There is positive Lasegue's on the right. There is positive straight leg raise on the right at 60 degrees. Motor is intact bilaterally. There is a healed surgical incision present. There is pain at L3-4 on the right side. Examination of the cervical spine reveals continued restricted range of motion, decreased range of motion, pain with range of motion, tenderness to palpation at facet joints, pain with axial compression. Diagnoses include 1) status post hardware removal, lumbar spine degenerative disc disease, chronic low back pain, breakdown C3-4 with HNP annular tear 2) history of previous L4-5 fusion 3) C4-5 and C5-6 disc bulging.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Series of Right Sided Lumbar Epidural Steroid Injections, L3-4: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections section Page(s): 46.

**Decision rationale:** The MTUS Guidelines recommend the use of epidural steroid injections (ESIs) as an option for treatment of radicular pain. Radicular pain is defined as pain in dermatomal distribution with corroborative findings of radiculopathy. Research has shown that less than two injections are usually required for a successful ESI outcome. A second epidural injection may be indicated if partial success is produced with the first injection and a third ESI is rarely recommended. ESI can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The treatment alone offers no significant long-term functional benefit. Criteria for the use of ESI include radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, and failed conservative treatment. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medications use for six to eight weeks. The injured worker has positive straight leg raise and MRI findings consistent with radiculopathy that may benefit from epidural steroid injection. A series of injections is not consistent with the recommendations of the MTUS Guidelines, however, as repeat injections should be based on objective documented pain and functional improvement. The request for Series of Right Sided Lumbar Epidural Steroid Injections, L3-4 is not medically necessary.