

<b>Case Number:</b>	CM14-0157683		
<b>Date Assigned:</b>	09/30/2014	<b>Date of Injury:</b>	09/13/2013
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	09/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2014

### 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 Family Medicine and is licensed to practice in Colorado. 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 36 year old male with date of injury 9/13/13, continues with mid back pain and low back pain. Patient has failed to achieve lasting relief with multiple therapies including non-steroidal anti-inflammatory drugs, Physical Therapy, Acupuncture, Chiropractic care, TENS, opioids, muscle relaxers, and Lyrica. He has ongoing anxiety / depression and sleep issues related to his chronic back pain, and records show he is in cognitive behavioral therapy and psychiatric medication management. Patient's T-spine MRI 4/10/2014 shows paracentral disc bulge and small annular tear at T8-T9, right side bulging more than left. Patient's mid-back symptoms are "band-like" around to chest and he has numbness and tingling in mid back. On one evaluation note he also had decreased sensation to ice in T8 dermatome. None of the multiple therapies patient has tried have provided lasting relief of mid-back pain or low back pain. Patient's L-spine MRI shows annular concentric, right protrusion greater than left, broad-based disc protrusion flattening and abutting the anterior and right thecal sac. Patient's low back symptoms include low back pain, worse with standing or walking, and radiating into right leg with numbness and tingling noted as well. Patient's EMG of lower extremities was Normal. As patient has failed other therapies, treating physician is requesting epidural steroid injection T8-T9.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Thoracic epidural steroid injection at T8-T9: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural Steroid Injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments, Page(s): 46. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: MEDLINE Literature review: Thoracic interlaminar epidural injections in managing chronic thoracic pain: a randomized, double-blind, controlled trial with a 2-year follow-up. Manchikanti L1, Cash KA, McManus CD, Pampati V, Benyamin RM. Pain Physician. 2014 May-Jun;17(3):E327-38. A systematic evaluation of thoracic interlaminar epidural injections. Benyamin RM, Wang VC, Vallejo R, Singh V, Helm li S. Pai

**Decision rationale:** MTUS Guidelines address epidural steroid injections in general and with regard to lumbar and cervical disorders, but thoracic injections are not addressed. ACOEM Guidelines do not specifically address thoracic epidural steroid injections. In addition to the MTUS, I have consulted Medline for review of available literature regarding thoracic epidural steroid injections. Per the MTUS, epidural steroid injections are recommended as an option for treatment of radicular pain. Current guidelines indicate no more than 2 epidural steroid injections are generally needed to achieve some relief of lumbosacral pain, and no evidence suggests relief is lasting. If initial epidural steroid injection does not provide at least 50% reduction in pain as well as some improvement in function, then additional injections are not indicated. Because pain relief is short term and no long term effects on function have been identified, epidural steroid injections are recommended as part of a program including other therapies such as exercise program. There is insufficient evidence to recommend cervical epidural steroid injections to treat cervical radicular pain. Per MTUS Guidelines, the following criteria should be used to determine which patient may benefit from epidural steroid injection: 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. There are few articles / studies in the medical literature regarding treatment with injections for chronic mid and upper back related to disc herniation / radiculitis, or other causes. Within MEDLINE, I reviewed a randomized, double-blind, active controlled trial and a retrospective review (which considered 17 studies but only found 2 relevant) regarding this issue and find no conclusive evidence to recommend thoracic epidural injections: One of the studies suggested possible benefit to epidural with and without steroids, but there was no placebo arm to that study. One of the studies showed "fair evidence" (reviewer's assessment) for epidural steroid injection use in various causes, so not specific to disc herniation or radiculopathy. One study showed no convincing evidence that thoracic epidural steroid injections would be helpful for postthoracotomy back pain. Also, patient's treating physician has requested approval of Neurostimulation therapy, with monitoring, and response to that request was not included in the records for review. If patient is going to try the Neurostimulation treatments, then he has not exhausted other options than injections. At this time,

no credible evidence-based recommendations exists for thoracic epidural steroid injections, and the request for thoracic epidural injection T8-T9 is not medically indicated.