

<b>Case Number:</b>	CM14-0038426		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	08/15/2005
<b>Decision Date:</b>	12/18/2014	<b>UR Denial Date:</b>	03/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/01/2014

### 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 Physical Medicine and Rehabilitation, 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 62-year-old male with a reported injury on 08/15/2005. The mechanism of injury was not provided. His diagnoses were noted to include lumbar disc degeneration and lumbosacral spondylosis without myelopathy. The injured worker's past treatments included medications, rest, cold compresses, a home exercise program, lumbar epidural steroid injections, and radiofrequency ablation at bilateral L4-5 and L5-S1 on 03/12/2013 and 11/12/2013. The injured worker's diagnostic testing included a lumbar spine MRI on 11/04/2011, which revealed enhancement in the posterior infraspinal ligaments behind the L2-3 suggesting synovitis (Baastrup's disease) or changes of ligamentous sprain and/or surgery. Correlate with physical exam to elicit tenderness to this region. Otherwise, no significant change in the above mentioned findings since the prior exam of 06/04/2009. No pertinent surgical history was provided. The injured worker was evaluated on 03/26/2014 for continued low back pain that radiated to the right lower extremity with associated numbness and weakness in the right lower extremity. The injured worker reported that both numbness and weakness had progressed and reduced his level of activity. He reported increasing Norco to 3 times per day. The injured worker reported that he had positive responses from previous epidurals and would like to continue to have them to alleviate his low back pain and right lower extremity pain and numbness. He wanted to continue the epidurals to increase his level of activity, walk longer durations, and reduce medication usage as previous lumbar epidural steroid injections had allowed him to do. The injured worker characterized his pain as dull, aching, and shooting, and rated the intensity a 7/10. The pain radiated to the right lower extremity and across the back. His pain was aggravated by daily activities of sitting, standing, and walking for an extended period of time. His pain was relieved by medication, rest, cold compresses, and stretching every day. The clinician observed and reported a lumbar motor examination with strength measured as 5/5 in all fields. There was

decreased sensation to light touch of the right lower extremity in a nondermatomal distribution. Tingling was noted along the lateral and posterior aspects of the right lower extremity. The straight leg raise was positive at 60 degrees on the left and 45 degrees on the right. The clinician indicated a request for an epidural steroid injection, reporting that the previous epidural steroid injection on 08/13/2013 offered 55% pain relief in the low back and right lower extremity for 4 months and then the pain slowly returned. Following the injection the injured worker was able to walk better, had more range of motion, had more mobility, had more energy due to the pain being reduced, and did not feel "worn out as much." Following the epidural steroid injection, he was able to reduce his Norco usage to 1 to 2 times per day. The clinician reported that the injured worker previously underwent physical therapy which did not alleviate the injured worker's pain. The injured worker's medications were noted to include ibuprofen 800 mg 3 times a day as needed, and Norco 10/325 mg 3 times a day as needed. The request was for lumbar caudal epidural steroid injection with fluoroscopy and conscious sedation. The rationale for the request was as described in the treatment plan. The Request for Authorization form was submitted 04/03/2014.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Lumbar caudal epidural steroid injection with fluoroscopy and conscious sedation:** Upheld

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

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

**Decision rationale:** The patient continued to complain of low back and right lower extremity numbness and weakness. The California MTUS Chronic Pain Guidelines recommend epidural steroid injections in patients with radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Radiculopathy must be initially unresponsive to conservative treatment. Injections should be performed using fluoroscopy. No more than 2 nerve root levels should be injected using transforaminal blocks. No more than 1 intralaminar level should be injected at 1 session. 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 6 to 8 weeks with a general recommendation of no more than 4 blocks per year. The provided documentation did not indicate lower extremity weakness or decreased sensation in a dermatomal distribution. Deep tendon reflexes were not documented. The request does not indicate which level or levels the epidural steroid injection(s) would be administered. Additionally, the request includes conscious sedation without a documented reason for such sedation, such as anxiety. The provided documentation fails to meet the evidence based guidelines for the requested service. Therefore, the request for lumbar caudal epidural steroid injection with fluoroscopy and conscious sedation is not medically necessary.