

<b>Case Number:</b>	CM14-0055837		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	09/14/1975
<b>Decision Date:</b>	08/21/2014	<b>UR Denial Date:</b>	04/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/25/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Texas and Oklahoma. 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 76-year-old female who reported an injury on 09/14/1975. The mechanism of injury was not provided. The injured worker's prior treatments included surgical intervention and physical therapy. The documentation of 03/12/2014 revealed the injured worker had a recent total knee arthroplasty. The injured worker had positive triggers in the bilateral lumbar spine. The toe walk was difficult to bilateral lower extremity motor deficits. The injured worker complained of low back pain and sometimes the pain was severe with pain radiating down both legs. The injured worker was noted to have 7 surgeries and numerous injections. The diagnosis included lumbago. The treatment plan included an epidural steroid injection and facet injection times 2 at L2-3.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar epidural steroid injection Lumbar 2-3 with facet injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections. Decision based on Non-MTUS Citation ODG- Low Back, Criteria for the use of Epidural steroid injections.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309, Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Medial Branch Block.

**Decision rationale:** The California MTUS guidelines recommend for repeat epidural steroid injection, there must be objective documented pain relief 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. Additionally, there is a recommendation that an epidural steroid injection is not to be performed on the same day as a trigger point injection, facet joint injection, or medial branch block. The clinical documentation submitted for review indicated the injured worker had prior epidural steroid injections times 6. There was a lack of documentation of objective functional benefit and documentation that the injured worker had at least 50% relief with an associated reduction in medication use for 6 to 8 weeks and there was a lack of documentation of objective functional improvement. The ACOEM Guidelines indicate that a facet neurotomy should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As ACOEM does not address medial branch diagnostic blocks, secondary guidelines were sought. Official Disability Guidelines indicate the criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings although pain may radiate below the knee, and a normal straight leg raise exam. There should be documentation of failure of conservative treatment including home exercise, physical therapy, and NSAIDs prior to the procedure for at least 4 to 6 weeks and no more than 2 facet joint levels should be injected in 1 session. Additionally, one set of diagnostic medial branch blocks is required with a response of 70%, and it is limited to no more than 2 levels bilaterally and they recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered under study). The clinical documentation submitted for review failed to provide documentation the injured worker had tenderness to palpation in the paravertebral area, a normal sensory examination, absence of radicular findings, and a normal straight leg raise exam. There was a lack of documentation of failure of conservative treatment. There was a lack of documentation indicating if the injured worker had prior facet injections and the objective functional benefit that was received. Given the above and the lack of documentation, the request for lumbar epidural steroid injection L2-3 with facet injection is not medically necessary.