

<b>Case Number:</b>	CM14-0058837		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	08/16/2010
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	04/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2014

### 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 Neurology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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:

An MRI lumbar spine from 10/03/13 indicated progressive degenerative disc disease without focal left-sided abnormality to explain left radicular symptoms. There was mild central L4-L5 broad based bulge protrusion, small central L5-S1 protrusion, and chronic L1-L2 disc degeneration present. Note November 7, 2011, indicates claimant with low back pain and left leg pain. Physical examination reported 5/5 strength in the lower extremity with reflexes 2+ and right lower extremity neurologically intact with normal gait. There was decreased sensation of left anterior thigh and medial lateral calf. There is a report on 11/27/13 which is a neurodiagnostic report. The study was reported to demonstrate normal findings. The reported findings suggested more of a lateral femoral cutaneous neuropathy clinically that would not be detected by electrodiagnostic study. Note January 2, 2014, indicates pain ongoing in the back. The pain is noted to be increased by activity and an epidural steroid injection was recommended. January 29, 2014, indicates continued care. Note 02/10/14 indicates a left L4-L5 transforaminal epidural steroid injection was performed. Note 02/18/14 indicated follow-up. The insured reported mild relief to date. The pain is reported to be 9/10 pre-block and 5/10 after the block. Examination indicated neurologically intact with normal strength, normal sensation, normal tone, normal reflexes and plan of care was to repeat the lumbar epidural.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**second epidural at L4-5 level: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines, Epidural Steroid Injections.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, epidural injections. Not recommended. Original recommendations that suggested a "series of three injections" generally did so prior to the advent of fluoroscopic guidance. These previous recommendations were based primarily on case studies and anecdotal evidence (Class IV and V data). (Abram, 1999) (Warr, 1972) (Hickey, 1987) There does not appear to be any evidence to support the current common practice of a series of injections. (Novak, 2008) Contemporary research studies with higher levels of evidence (including two controlled trials) have suggested that on average, two or less ESIs are required in patients with successful outcomes from the use of ESIs to treat disc related lumbar radiculopathy. (Lutz, 1998) (Vad, 2002) (Riew, 2000) While all of these latter studies have utilized repeat injections, there has been no evidence-based research to explain why this practice is required, or the mechanism for possible action. Since the introduction of fluoroscopically guided ESIs, it has been suggested that there is little evidence to repeat an accurately placed epidural injection in the presence of mono-radiculopathy, regardless of whether there is partial or no response. (McLain, 2005) A recent randomized controlled trial of blind ESIs found no evidence to support repeat injections, because at six weeks there was no significant difference found between the ESI group and a placebo controlled group in terms of any measured parameter. (Price, 2005) A repeat injection has been suggested if there is question of accurate dermatomal diagnosis, if pain may be secondary to a different generator, or in the case of multilevel pathology. (McLain, 2005) There is a lack of support for 2nd epidural steroid injection if the 1st is not effective. (Cuckler, 1985) With fluoroscopic guidance, there is little support to do a second epidural if there is no response to the first injection. There is little to no guidance in current literature to suggest the basis for the recommendation of a third ESI, and the routine use of this practice is not recommended.

**Decision rationale:** The documented pain relief is less than 50% (9/10 to 5/10) and as such repeat injection is not supported under ODG guidelines. The follow-up physical examination indicates no physical findings supportive of radiculopathy, and as such does not support repeat injection. Therefore, Second epidural at L4-5 level is not medically necessary.