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| <b>Case Number:</b>   | CM14-0188861 |                              |            |
| <b>Date Assigned:</b> | 11/20/2014   | <b>Date of Injury:</b>       | 02/27/2014 |
| <b>Decision Date:</b> | 01/09/2015   | <b>UR Denial Date:</b>       | 10/13/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/12/2014 |

### 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 Neuromuscular Medicine and is licensed to practice in New Jersey. 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 patient is a 64-year-old woman who sustained a work-related injury on February 27, 2014. Subsequently, the patient developed chronic low back pain. MRI of the lumbar spine date June 5, 2014 showed at L4-5, mild to moderate central canal stenosis secondary to degenerative disc disease, a 4 mm broad-based disc/osteophyte complex bulge with focal left lateral prominence and hypertrophic facet degenerative changes. There was moderate to severe left and mild right neural foraminal narrowing. At L3-4, endplate alteration of marrow signal intensity was seen. There was a 4-5 mm broad-based posterior disc complex bulge with focal left lateral prominence. Bilateral hypertrophic facet degenerative changes were seen, left greater than right. There was also moderate central canal stenosis. At L5-S1, there was loss of height and endplate alteration of marrow signal intensity. There was 6-7 mm broad-based posterior disc complex bulge extending into bilateral neural foramina causing severe bilateral neural foraminal narrowing with impingement on bilateral L4 nerve roots. There was mild central canal stenosis. At L2-3, there was loss of height and endplate alteration of marrow signal intensity. A 3-4 mm broad-based posterior disc complex bulge with right lateral prominence was seen causing mild to moderate right neural foraminal narrowing. There was mild left neural foraminal narrowing. According to a progress report dated October 20, 2014, the patient complained of intermittent pain in the cervical spine. The pain was characterized as dull. The patient's pain was improving and rated her pain as a 4/10. The patient also complained of constant pain in the low back. The pain was characterized as sharp/stabbing. There was radiation of pain into the right lower extremity to the toes with associated tingling and numbness. The patient's pain was worsening. She rated her pain as a 9/10. There was intermittent pain in the bilateral shoulders. The pain was characterized as dull. Her pain was improving and she rated it as a 5/10. There was frequent pain in the bilateral hips and thighs. The pain was characterized as sharp/throbbing. The patient's pain

was worsening. She rated her pain as a 10/10. Examination of the lumbar spine revealed pain and tenderness right across the iliac crest into the lumbosacral spine, much more pronounced on the right side than on the left side. Range of motion: standing flexion and extension were guarded and restricted. There was radiculopathy into the right lower extremity in what appeared to be the right L5 and S1 roots and dermatome. The patient was diagnosed with cervical/lumbar discopathy and internal derangement right hip. The provider requested authorization for L3-4 Epidural Steroid Injection.

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

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

#### **L3-4 Epidural Steroid Injection: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** According to MTUS guidelines, epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit; however there is no significant long term benefit or reduction for the need of surgery. Furthermore, the patient file does not document that the patient is candidate for surgery. In addition, there is no evidence that the patient has been unresponsive to conservative treatments. Furthermore, there is no recent clinical and objective documentation of radiculopathy. There is no documentation of radiculopathy at L3-4, the requested levels of injections. MTUS guidelines do not recommend epidural injections for back pain without radiculopathy. Therefore, L3-4 Epidural Steroid Injection is not medically necessary.