

<b>Case Number:</b>	CM14-0203029		
<b>Date Assigned:</b>	12/15/2014	<b>Date of Injury:</b>	07/02/2014
<b>Decision Date:</b>	02/05/2015	<b>UR Denial Date:</b>	11/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/04/2014

### 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 Anesthesiology, has a subspecialty in 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:

56y/o female injured worker with date of injury 7/2/14 with related low back pain. Per progress report dated 8/24/14, the injured worker complained of lower back pain for one month that was worsening. She felt the pain more when she bended forward. The lower back pain radiated to both legs and she sometimes felt weakness of her right leg which was on and off. Per physical exam, there was spasm noted. MRI of the lumbar spine dated 4/2013 revealed lateral disc protrusion L5-S1 on the right causing posterior disc displacement and compression of the right S1 nerve root. Treatment to date has included physical therapy, and medication management. The date of UR decision was 11/24/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar Epidural Steroid Injections:** Upheld

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

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

**Decision rationale:** Per the MTUS CPMTG Epidural Steroid Injections are used to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active

treatment programs and avoiding surgery, but this treatment alone offers no significant long-term benefit. The criteria for the use of Epidural Steroid Injections are as follows: 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. 8) Current research does not support "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The documentation submitted for review does not contain physical exam findings of radiculopathy. Above mentioned citation conveys radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Radiculopathy is defined as two of the following: weakness, sensation deficit, or diminished/absent reflexes associated with the relevant dermatome. These findings are not documented, so medical necessity is not affirmed. Furthermore, the requested level of injection was not specified. As the first criteria are not met, the request is not medically necessary.