

<b>Case Number:</b>	CM15-0141298		
<b>Date Assigned:</b>	07/31/2015	<b>Date of Injury:</b>	02/01/2008
<b>Decision Date:</b>	09/24/2015	<b>UR Denial Date:</b>	06/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/21/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

### 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 54 year old male, who sustained an industrial injury on 2-1-2008. The mechanism of injury is not indicated. The injured worker was diagnosed as having status post left total knee replacement, lumbar disc disease with radiculitis, lumbosacral sciatica syndrome compensatory. Treatment to date has included medications, lumbar epidural steroid injections, and electrodiagnostic studies, left knee total replacement (9-20-2013). The request is for 3 sets of left side L5 nerve root lumbar epidural injections. An AME report dated 2-4-2015, indicates he reported left knee pain, right knee pain, and a new onset lumbosacral pain with sciatica. The AME noted upon review of the medical records regarding the lumbosacral spine he would benefit from 2 more epidural steroid injections. He is reported to have completed 5 acupuncture sessions with no benefit. He presently reported left knee pain, compensatory right knee pain, and intermittent low back pain in the left lateral aspect with radicular pain to the lower extremities. He also indicated there to be associated numbness and tingling in the left lower limb and weakness of the left leg. He indicated going up and down stairs, squatting and bending gives him pain in the low back. He rated his current low back pain 4 out of 10, his average pain 3, worst 7, with activities 6. He is placed on work restrictions, and future medical care recommendations given for the low back are: ongoing oral analgesics, muscle relaxants, and anti-inflammatory medications, intermittent lumbar epidural corticosteroid injection as well as L5 transforaminal block may be necessary occasionally during periods of exacerbation. The provider noted injection may be helpful if there are localized symptoms to areas of the bursa. Surgery was not indicated. The AME went on to recommend ongoing flexion postural exercises and orthotic

supports. The physical examination revealed tenderness in the midline low back area, tenderness over the bilateral paraspinals musculature, tenderness over the greater sciatic notches and posterior thighs bilaterally. Normal posture was noted, normal heel toe gait, pelvis level, and Trendelenburg and Fabere tests were negative bilaterally. When he stood on his heels and toes, he complained of bilateral knee pain, and pain with extreme forward flexion and extension and extreme right and left lateral bending of the lumbar spine. He was positive at 70 degrees on the right during straight leg raise testing noting pain in the low back with radiation into the buttocks, and positive at 75 degrees on the left. In the sitting position, straight leg raise testing elicited positive results at 80 and 85 degrees bilaterally cause pain to the low back with radiation into the buttocks. There were no new x-rays taken on this date. The AME noted a magnetic resonance imaging dated 2-5-2014 showed bulging and mild left greater than right central canal stenosis and slight central and neural foraminal stenosis. The magnetic resonance imaging report is not available for this review. On 2-27-2015, he reported constant low back pain with radiation to the left posterior thigh and burning numbness to the left lateral calf. There is left sciatic notch soreness noted with diminished sensation to the left lateral calf and dorsum and lateral left foot, and a negative straight leg raise test. On 4-14-2015, he reported low back pain with radiation to the left hip and left posterior lateral thigh. On examination there is soreness noted to the right gluteal and his pelvis is level. The treatment plan included: Norco, Lidocaine patches and follow up in 3 weeks. On 5-26-2015, he reported persistent pain and numbness to the left leg. He reported walking good but with pain to the tibia. On examination the lumbar spine is noted to have soreness in the left gluteal. The treatment plan included: Norco, Fexmid, stable but consider a lumbar epidural and follow up in 6 weeks.

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

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

**3 sets of left side L5 nerve root lumbar epidural injection:** 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 9792.20-9792.26 Page(s): 46 of 127.

**Decision rationale:** Regarding the request for 3 sets of left side L5 nerve root lumbar epidural injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Guidelines recommend that no more than one interlaminar level, or two transforaminal levels, should be injected at one session. Regarding repeat epidural injections, guidelines state that 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. Furthermore, guidelines state that most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence.

Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Within the documentation available for review, there are recent subjective complaints and objective examination findings supporting a diagnosis of radiculopathy. Additionally, there are imaging or electrodiagnostic studies corroborating the diagnosis of radiculopathy. However the request for 3 sets is not recommended by guidelines. As such, the currently requested 3 sets of left side L5 nerve root lumbar epidural injection is not medically necessary.