

<b>Case Number:</b>	CM15-0149385		
<b>Date Assigned:</b>	08/12/2015	<b>Date of Injury:</b>	01/03/2015
<b>Decision Date:</b>	09/15/2015	<b>UR Denial Date:</b>	07/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2015

### 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, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 38 year old male who sustained an industrial injury on 1-3-2015. He has reported low back pain radiating to the buttocks with occasional paresthesias in the leg and has been diagnosed with lumbar disc protrusion, L5-S1 and lumbar spine myoligamentous sprain strain. Treatment has included physical therapy. There was no scoliosis to the lumbar spine. There was slight tenderness in the lumbar paravertebral muscles. There was no spasm of the lumbar paravertebral muscles. With direct palpation, there was no generalized tenderness in the lumbar spine. There was no tenderness in the right and left sacroiliac joints bilaterally. There was no tenderness in the right and left sciatic notches bilaterally. Range of motion caused low back pain. Straight leg raising was to 50 degrees, bilaterally, without pain in the lower back region. The treatment plan included epidural injections, physical therapy, and follow up. The treatment request included epidural at L5-S1 x 2 under fluoroscopic guidance and IV sedation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Epidural at L5-S1 x2 under fluoroscopic guidance and IV sedation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 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 or clinical evidence of radiculopathy. MRI of the lumbar spine dated 2/2/15 revealed a 5mm disc protrusion at L5/S1; there was no foraminal stenosis or nerve root impingement. The MRI findings documented do not demonstrate findings consistent with 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. As the first criteria are not met, the request is not medically necessary. Furthermore, the request for two injections is inappropriate.