

<b>Case Number:</b>	CM15-0184250		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	07/15/2014
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	09/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2015

### 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 45 year old female who sustained an industrial injury on 07-15-2014. The injured worker was diagnosed with lumbar spine myospasm and myalgia with bilateral lower extremity radiculopathy. According to the treating physician's progress report on 08-11-2015, the injured worker continues to experience low back pain rated as 6-7 out of 10 on the pain scale associated with numbness and tingling in the bilateral lower extremities. Examination of the lumbar spine demonstrated tenderness to palpation over the paraspinal muscles. Range of motion was decreased with flexion at 50 degrees and extension at 15 degrees. Neurovascular status was intact. Prior diagnostic testing with lumbar spine magnetic resonance imaging (MRI) was performed on 12-05-2014 and Electromyography (EMG) and Nerve Conduction Velocity (NCV) studies of the lumbar spine and lower extremities documented no electrical evidence of radiculopathy and no peripheral nerve compression noted at this time. A Functional Capacity Evaluation (FCE) was performed on June 22, 2015. Prior treatment included acupuncture therapy and modified work restrictions. Medications were not noted. Treatment plan consists of dispensing Naproxen and Pantoprazole and on 08-11-2015, the provider requested authorization for a L4-L5 epidural steroid injection times one. On 09-08-2015, the Utilization Review determined the request for L4-L5 epidural steroid injection times one was not supported as medically necessary.

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

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

### **Lumbar epidural steroid injection times 1 L4-L5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**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 a 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 12/5/14 revealed at L4-L5 a 2mm broad based disc bulge, facet and ligamentum flavum hypertrophy and bilateral neural foraminal narrowing, no canal stenosis. 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 is not met, the request is not medically necessary.