

<b>Case Number:</b>	CM15-0184751		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	09/24/2012
<b>Decision Date:</b>	11/04/2015	<b>UR Denial Date:</b>	08/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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: Washington, California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 37 year old female injured worker suffered an industrial injury on 9-24-2012. The diagnoses included chronic low back pain with L5 and S1 radicular pain secondary to lumbago with radiculitis, probable lumbar radiculopathy and cervical cervicalgia. Prior treatment included physical therapy, TENS unit, epidural steroid injection and medication (Tylenol, Flexeril, Nucynta, Topamax, and Baclofen). Lumbar MRI on 1-2-15 reported minor disc desiccation with slight annular bulging and end plate remodeling, worse at L5-S1; conjoined left L5-S1 nerve root sleeves; combined effect of these conditions result in mild to moderate left-sided subarticular recess narrowing and mild left foraminal stenosis. On 8-13-2015, the treating provider reported severe low back pain radiating to the left leg and neck pain. She stated physical therapy made the pain worse, and TENS was helpful. She had lumbar epidural injection a few years ago but the medical records available for review did not give details of effectiveness. On exam the cervical spine, lumbar spine, buttocks and upper back were tender. The straight leg raise was positive and the patient had an impaired gait. Request for Authorization for epidural steroid injection was dated 8-14-2015. On 9-9-2015 the treating provider reported continued 5/10 neck pain and 8/10 low back pain with radiation into bilateral legs. Exam showed numbness in dorsum of left foot and normal lower extremity motor strength. The Utilization Review on 8-21-2015 determined non-certification for left L5 and S1 transforaminal epidural steroid injection under fluoroscopy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left L5 and S1 transforaminal epidural steroid injection under fluoroscopy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care, Summary, and Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation American Society of Interventional Pain Physician: Comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations.

**Decision rationale:** The best medical evidence today for individuals with low back pain indicates that having the patient return to normal activities provides the best outcomes. Therapy should be guided, therefore, with modalities that will allow this outcome. Epidural steroid injections are an optional treatment for pain caused by nerve root inflammation as defined by pain in a specific dermatome pattern consistent with physical findings attributed to the same nerve root. As per the MTUS, the present recommendations are for no more than 2 such injections, the second being done only if there is at least a partial response from the first injection. Its effects usually will offer the patient short-term relief of symptoms, as they do not usually provide relief past 3 months, so other treatment modalities are required to rehabilitate the patient's functional capacity. The American Society of Interventional Pain Physicians (ASIPP) found limited evidence for accuracy of diagnostic nerve blocks but recommends diagnostic selective nerve root blocks in the lumbar spine in select patients with an equivocal diagnosis and involvement of multiple levels. Therapeutically, ASIPP noted good evidence for use of epidural steroid injections for managing disc herniation or radiculitis; fair evidence for axial or discogenic pain without disc herniation, radiculitis or facet joint pain with caudal and lumbar interlaminar epidural injections, and limited evidence with transforaminal epidural injections. The MTUS provides very specific criteria for use of this therapy. Specifically, the presence of a radiculopathy documented by examination and corroborated by imaging, and evidence that the patient is unresponsive to conservative treatment. For this patient there is fair documentation on history and examination of the radicular nature of the patient's symptoms which is somewhat corroborated by MRI and good evidence that the patient is unresponsive to conservative therapy. However, the patient had a prior lumbar epidural steroid injection (LESI) for which there is no available documentation that it help relieve her symptoms. In this situation, a second LESI is not recommended. At this point in the care of this patient for this procedure is not medically necessary and has not been established.