

<b>Case Number:</b>	CM15-0185641		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	12/28/2004
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	08/27/2015
<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: Massachusetts

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 51 year old male with an industrial injury dated 12-28-2004. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar discogenic disease, status post lumbar spine hardware removal, status post lumbar fusion and right rotator cuff tear. Medical records (03-31-2015 to 07-15-2015) indicate ongoing low back pain status post lumbar spine hardware removal and right shoulder pain. According to the progress note dated 03-31-2015 to 07-15-2015, pain level was 9 out of 10 on a visual analog scale (VAS). The injured worker reported a decrease in pain with medications, 50% improvement and increase function. Objective findings (03-31-2015 to 07-15-2015) revealed spasm, painful limited range of motion, positive bilateral straight leg raises, pain in bilateral L4-L5 and L5-S1, tenderness to palpitation over the lumbar paraspinal musculature, and decreased bilateral L4-S1. Treatment has included diagnostic studies, prescribed medications, and periodic follow up visits. The treatment plan consisted of transcutaneous electrical nerve stimulation (TENS) unit, medication management, lumbar epidural steroid injection (ESI), right shoulder evaluation and follow up visit. There was no Magnetic Resonance Imaging (MRI) of lumbar spine report included for review. Request for authorization dated 08-19-2015, included requests for lumbar epidural steroid injection (LESI) L4-S1 bilaterally times 1. The utilization review dated 08-27-2015, non-certified the request for LESI L4-S1 bilaterally times 1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **LESI L4-S1 bilaterally times 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

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

**Decision rationale:** Accordingly, to the MTUS, epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatome distribution with corroborative findings of radiculopathy). See specific criteria for use below. 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. Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three." Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is 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 functional benefit. 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. According to the documents available for review, the current request for injection bilaterally L4-S1 exceeds the total number of injections that should be attempted at one time as stated in the MTUS above. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established. Therefore, the request is not medically necessary.