

<b>Case Number:</b>	CM15-0194035		
<b>Date Assigned:</b>	10/07/2015	<b>Date of Injury:</b>	09/02/2005
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	09/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2015

### 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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 65-year-old female who sustained an industrial injury 09-02-05. A review of the medical records reveals the injured worker is undergoing treatment for degenerative thoracic-lumbar intervertebral disc, and spinal stenosis. Medical records (09-15-15) reveal the injured worker complains of "severe" pain rated at 4-5/10 with medications, and 8/10 without medications. The physical exam (09-15-15) reveals tenderness to palpation throughout the lumbosacral region, and intact to pinprick sensation in all lower extremities. Prior treatment includes medications, lumbar epidural steroid injection in 04-15, lumbar fusion L4-S1 with subsequent removal of hardware. The injured worker reports greater than 50% relief of her pain since the lumbar epidural steroid injection in 04-15, but that now her symptoms are recurring. She currently treats her symptoms with Lyrica and Tramadol, and rarely (a few times per week) Norco. The treating provider reports the CT of the lumbar spine (05-10-13) at L3-4 there is evidence of a posterior osteophyte complex with possible neural foramen narrowing. An undated MRI is reported to show moderate sized disc protrusions at L2-3 and L3-4 causing moderate central canal stenosis. Another undated CT of the lumbar spine is reported to reveal central canal and lateral recess stenosis at L2-4 with disc bulges. The original utilization review (09-23-15) non-certified the request for a Lumbar epidural steroid injection a L3-4 under fluoroscopy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar Epidural Steroid Injection at L3-L4 with Fluoroscopic Guidance: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections (ESIs), therapeutic.

**Decision rationale:** MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). 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." ACOEM states: "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain." MTUS further defines the criteria for epidural steroid injections to include: 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 medical documentation provided indicate this patient had a previous ESI injection in 04/2015. The medical documentation provided indicate this patient had a 50% reduction in pain for greater than 8 weeks. As such, the request for Lumbar Epidural Steroid Injection at L3-L4 with Fluoroscopic Guidance is medically necessary.