

<b>Case Number:</b>	CM15-0204166		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	08/11/2010
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	09/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2015

### 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, Oregon, Washington  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 32 year old male, who sustained an industrial injury on 8-11-2010. Several documents in the provided medical records are not legible. The injured worker was being treated for lumbar or lumbosacral spinal stenosis, lumbar degenerative disc disease with herniated nucleus pulposus at L4-5 (lumbar 4-5), lumbar radiculopathy, and myospasms with myofascial trigger points. The injured worker (4-21-2015) reported lower back pain radiating to the right lower extremity, rated 7 out of 10. The physical exam (4-21-2015) reveals tenderness at L3-5 (lumbar 3-5) and decreased flexion at 50 degrees. The injured worker (8-7-2015) reported ongoing lower back pain radiating to the bilateral lower extremities, rated 8 out of 10. Lying down and a transcutaneous electrical nerve stimulation (TENS) unit help the pain. Coughing, walking, sitting, bending, and lying down for prolonged periods of time worsens the pain. The physical exam (8-7-2015) reveals a slow and wide based gait and inability to toe and heel walk due to lower back pain. The provider stated that there was pain with lumbar forward flexion to 10 degrees, extension to 10 degrees, right side bending at 5 degrees, and left side bending at 5 degrees. The provider stated that there were myospasms with myofascial trigger points and referred pain with twitch response along the lumbosacral paraspinal. The provider stated that there decreased sensation in the bilateral L4 and L5 distributions. Per the treating physician (8-7-2015 report) an MRI of the lumbar spine (dated 3-14-2014) revealed developing degenerative disc signal at L3-4 (lumbar 3-4) and L4-5 and mild facet joint disease at bilateral L5-S1 (lumbar 5-sacral 1). Per the treating physician there was a central and paracentral disc bulge at L3-4 with a central annular tear and mild effacement of the thecal sac, but no compression of the proximal

L4 roots. Per the treating physician there was a moderate central and paracentral disc protrusion at L4-5 effacing the thecal sac extending laterally to the exit point of the L5 rootlets, without compression or displacement of the L5 rootlets. Per the treating physician there was moderate foraminal stenosis secondary to lateral disc osteophyte formation. Treatment has included physical therapy, work restrictions, a TENS unit, a cortisone injection, a lumbar epidural steroid injections, and medications including pain, muscle relaxant, anti-epilepsy, and non-steroidal anti-inflammatory. Per the treating physician (8-7-2015 report), the employee has not returned to work. The treatment plan included a transforaminal epidural steroid injection at L4-5 and L5-S1. On 9-11-2015, the requested treatments included an epidural steroid injection (L4-5 and L5-S1) for the lumbar injury. On 9-18-2015, the original utilization review non-certified a request for an epidural steroid injection (L4-5 and L5-S1) for the lumbar injury.

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

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

**Epidural steroid injection (L4-5 and L5-S1) for the lumbar injury, outpatient:** 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:** According to the CA MTUS Chronic Pain Medical Treatment Guidelines, Epidural injections, page 46, "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." Specifically the guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. 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. In addition there must be demonstration of unresponsiveness to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). CA MTUS criteria for epidural steroid injections are: "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."In this case the exam notes from 8/7/15 do not demonstrate a failure of conservative management or a clear evidence of a dermatomal distribution of radiculopathy. No more than one interlaminar level should be injected at one session. Therefore the determination is for non-certification. The request is not medically necessary.