

<b>Case Number:</b>	CM15-0208910		
<b>Date Assigned:</b>	10/28/2015	<b>Date of Injury:</b>	10/22/2010
<b>Decision Date:</b>	12/15/2015	<b>UR Denial Date:</b>	10/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2015

### 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 50 year old male, who sustained an industrial injury on 10-22-2010. The injured worker was being treated for herniation of lumbar intervertebral disc, lumbago, and lumbar radiculopathy. The injured worker (8-31-2015) reported ongoing low back pain. The physical exam (8-31-2015) revealed back flexion limited at 20 degrees due to pain and tenderness over the bilateral L3-5 (lumbar 3-5) paraspinal muscles. The injured worker (9-22-2015) reported ongoing pain in the bilateral L4-S1 (lumbar 4-sacral 1) midline and paralumbar areas radiating down both legs to the 2nd and 3rd toes with numbness there also. The physical exam (9-22-2015) revealed tenderness, pain, and normal range of motion of the lumbar back. The injured worker (9-24-2015) reported ongoing low back pain radiating down the bilateral lateral and posterior lower extremities. The treating physician noted the injured worker had been given a lumbar epidural steroid injection in 5-2015, which provided "significant pain relief for about 6 weeks then the pain slowly returned." The injured worker reported his pain was "the same as before." The treating physician noted that physical exam (9-24-2015) was deferred. The MRI of the lumbar spine (dated 12-10-2014) stated: At L1-2 (lumbar 1-2), there was disk space narrowing and a minimal diffuse disc bulge without canal or neuroforaminal narrowing. At L2-3 (lumbar 2-3), there was disk space narrowing and a small diffuse disc bulge without canal or neuroforaminal narrowing. At L3-4 (lumbar 3-4), there was a 4 mm right paracentral disc protrusion or extrusion causing mass effect on thecal sac with crowding of the roots, which was similar to the prior study. At L4-5 (lumbar 4-5), there was a small diffuse disc bulge without significant neuroforaminal narrowing. L5-S1 (lumbar 5-sacral) was unremarkable. In addition,

the MRI stated that the overall findings were stable to improved compared to the prior exam. The electromyography and nerve conduction studies (dated 4-6-2015) stated there were chronic neurogenic changes in the right L3-4 innervated muscles, which could be suggestive of chronic L3-4 right radiculopathy. Treatment has included lumbar epidural steroid injections, off work, work restrictions, and medications including pain, antidepressant, and non-steroidal anti-inflammatory. Per the treating physician (9-22-2015 report), the injured worker was placed on modified work (applies to home and work). The requested treatments included a pain block consultation, lumbar epidural steroid injection at L5, and outpatient anesthesia. On 10-12-2015, the original utilization review non-certified requests for a pain block consultation, lumbar epidural steroid injection at L5, and outpatient anesthesia.

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

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

#### **Pain Block Consultation: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Prevention, General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment, Cornerstones of Disability Prevention and Management.

**Decision rationale:** ACOEM Chapter 2 on General Approaches indicates that specialized treatments or referrals require a rationale for their use. According to the documents available for review, there is no rationale provided to support a referral for a pain block. It is unclear what the specific nature of the request is as there is no rationale provided. Therefore, at this time, the requirements for treatment have not been met. The request is not medically necessary.

#### **Outpatient Lumbar Epidural Steroid Injection at L5: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** According 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. 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 IW does have physical exam findings and pain complaints that are corroborated by imaging studies and as required by the MTUS above. Therefore, at this time, the requirements for treatment have been met. The request is medically necessary.

**Outpatient Anesthesia:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Prevention, General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment, Cornerstones of Disability Prevention and Management.

**Decision rationale:** ACOEM Chapter 2 on General Approaches indicates that specialized treatments or referrals require a rationale for their use. According to the documents available for review, there is no rationale provided to support the use of outpatient anesthesia. Therefore, at this time the requirements for treatment have not been met. The request is not medically necessary.