

<b>Case Number:</b>	CM15-0209226		
<b>Date Assigned:</b>	10/28/2015	<b>Date of Injury:</b>	08/20/2012
<b>Decision Date:</b>	12/11/2015	<b>UR Denial Date:</b>	09/26/2015
<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: 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 58 year old female with a date of injury on 08-20-2012. The injured worker is undergoing treatment for persistent low back and lower extremity symptoms. A physician procedure note dated 04-30-2015 documents the injured worker received a lumbar epidural steroid injection at L5-S1, facet joint injections at bilateral L4-L5 and L5-S1, interpretation of neurogram-myelogram, interpretation of arthrogram bilateral facet joints at L4-L5 and L5-S1, and injection of Marcaine and Betamethasone under Fluoroscopy. Treatment to date has included diagnostic studies, medications, physical therapy, and acupuncture. A Magnetic Resonance Imaging of the lumbar spine done on 12-24-2014 revealed multilevel disc bulges with stenosis of the bilateral neural foramen contacting bilateral transiting nerve roots. There is a hemangioma at L2, and L5. There is disc desiccation at L2-L3 through L5-S1. An Electromyography done on 01-12-2015 revealed no electroneurographic evidence of entrapment neuropathy was seen in the lower extremities. Electromyography indications of acute lumbar radiculopathy were not seen. On 09-26-2015, Utilization Review non-certified the request for Retro Anesthesia in lumbar region given during epidural steroid injection with a DOS of 4/30/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Anesthesia in lumbar region given during epidural steroid injection with a dos of 4/30/2015:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**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. Radiculopathy does appear to be documented with imaging studies. Additionally, treatment notes do indicate other conservative treatments were tried and failed (exercises, physical therapy, etc). As such, the request for Retro Anesthesia in lumbar region given during epidural steroid injection with a dos of 4/30/2015 is medically necessary.