

<b>Case Number:</b>	CM15-0021662		
<b>Date Assigned:</b>	02/11/2015	<b>Date of Injury:</b>	07/02/2013
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2015

### 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: Arizona, California  
 Certification(s)/Specialty: Family Practice

### 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 53 year old male, who sustained a work/ industrial injury on 7/2/13. He has reported symptoms of low back pain, greater than right lower extremity pain, neck pain greater than left upper extremity pain. Prior medical history was noncontributory. The diagnosis was lumbago. Treatments to date included medication, physical therapy, and epidural steroid injections. Diagnostics included a Magnetic Resonance Imaging (MRI) from 12/4/13 that reported moderate to severe foraminal stenosis at L3-L4, moderate to severe foraminal narrowing at L4-5, intraforaminal nerve impingement by a large L5 articular process at L4-L5. And a disc bulge at L5-S1 with associated arthropathy and neural foraminal stenosis. Electromyogram/NCV study demonstrated left C6, C7 radiculopathy and left carpal tunnel syndrome as well as right sided L5 and S1 radiculopathy. Examination on 12/10/14 noted symptoms waxing and waning of symptoms in his low back. There were also complaints of neck, right hip/groin, and right shoulder pain. There was pain with extension as well as tenderness over the Para lumbar extensors. Range of motion was limited due to pain and stiffness. Straight leg raises was positive on the right and negative on the left. There was 5/5 strength of the bilateral lower extremities with exception of trace weakness with right ankle dorsiflexion/plantar flexion. Sensation was intact and deep tendon reflexes were symmetrical. On 1/9/15, Utilization Review non-certified a Transforaminal epidural steroid injection at right L3, L4, L5, noting the Medical treatment Utilization Schedule (MTUS), Chronic Pain Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transforaminal epidural steroid injection at right L3, L4, L5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural injections Page(s): 47.

**Decision rationale:** According to the MTUS guidelines: 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 ACOEM guidelines, epidural steroid injections are not recommended. Invasive techniques are of questionable merit. Epidural Steroid Injections may provide short-term improvement for nerve root compression due to a herniated nucleus pulposus. The treatments do not provide any long-term functional benefit or reduce the need for surgery. In this case, the request was for 3 levels of injections. There was mention of receiving lumbar epidural injections 1 tr prior that only benefited a few weeks. In addition, there is no mention of performing the procedure on fluoroscopy. The request, therefore, for a lumbar epidural steroid injections is not medically necessary.