

<b>Case Number:</b>	CM15-0217060		
<b>Date Assigned:</b>	11/06/2015	<b>Date of Injury:</b>	06/25/2013
<b>Decision Date:</b>	12/18/2015	<b>UR Denial Date:</b>	10/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2015

### 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 51 year old female who sustained an industrial injury on 6-25-13. Medical records indicate that the injured worker has been treated for lumbosacral strain; lumbosacral neuritis; anterolisthesis L5-S1, grade 1; cervical strain; cervical neuritis; pain flare; depression. She currently (9-28-15) complains of continued neck pain with radiation to bilateral upper extremities with a pain level of 7 out of 10 and sharp low back pain with a pain level of 9 out of 10. Physical exam revealed decreased range of motion of the lumbar spine, tenderness to palpation, spasms on the right, diminished sensation to light touch on the right L2-S1, positive straight leg raise on the right; decreased cervical range of motion, diffuse tenderness to palpation. Diagnostics include electromyography-nerve conduction study (3-2015) showing right sided lumbar radiculopathy involving nerve root S1; MRI of the lumbar spine (2-2015) showing degenerative disc disease and facet arthropathy and restrolisthesis at L3-4, L4-5 and grade 1 anterolisthesis L5-S1, canal stenosis L3-4, L4-5, L5-S1, neuroforaminal narrowing at L4-5 right, L5-S1 left. Treatment to date includes medication: naproxen, cyclobenzaprine, gabapentin, Lidopro topical, duloxetine; chiropractic sessions; transcutaneous electrical nerve stimulator unit; lumbar support; acupuncture. Prior lumbar epidural steroid injections were not indicated. The request for authorization dated 9-28-15 was for lumbar epidural steroid injection L3-4 and L4-5 times 1. On 10-29-15 Utilization Review non-certified the request for lumbar epidural steroid injection L3-4 and L4-5 x1.

### 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 and L4-L5 x1: Upheld**

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

**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 9/28/15 do not demonstrate a failure of conservative management nor a clear evidence of a dermatomal distribution of radiculopathy. Per CA MTUS guidelines no more than one interlaminar level should be injected at one session. Therefore epidural steroid injection is not medically necessary and the determination is for non-certification, not medically necessary.