

<b>Case Number:</b>	CM15-0220844		
<b>Date Assigned:</b>	11/16/2015	<b>Date of Injury:</b>	10/06/2009
<b>Decision Date:</b>	12/24/2015	<b>UR Denial Date:</b>	10/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2015

### 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: Washington, California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 30 year old male who sustained an industrial-work injury on 10-6-09. A review of the medical records indicates that the injured worker is undergoing treatment for cervical and lumbar degenerative disc disease (DDD), cervical radiculopathy, and cervical sprain. Comorbid conditions include morbid obesity BMI 48.03. Per the treating physician report dated 10-29-15 the work status is temporary totally disabled. Treatment to date has included pain medication (Percocet, OxyContin, Xanax, Cymbalta, Celebrex, Amitriptyline, Gabapentin (did not tolerate), Trazodone, Opana ER, Nucynta, Butrans), rest, labs, diagnostics, Functional Capacity Evaluation (FCE), and physical therapy with minimal temporary relief. Magnetic resonance imaging (MRI) of the cervical spine dated 6-8-15 revealed area of stenosis at C6-7. The MRI of the lumbar spine dated 6-8-15 revealed L5-S1 disc bulge and annular tear, and mild bulging L4-5. Medical records dated 10-8-15 indicated that the injured worker complained of his hands going to sleep when he lies on his back. He required a walker to ambulate. He reported most pain was in the low back and thoracic-lumbar area. He also had upper extremity right sided radicular symptoms described as shooting, stabbing, crushing, burning and radiating and complained of chronic headaches. The physical exam revealed decreased cervical range of motion with pain on motion, muscle spasm in the cervical spine, sensation was normal in the C3-7 and L1-L5 distribution, Spurling sign is positive bilaterally, left shoulder strength was 4/5 with give way weakness in bilateral upper extremities C5-T1 distribution. There was also decreased lumbar range of motion with pain on motion, lumbar tenderness, muscle spasm in the lumbar spine, and positive straight leg raise at 30 degrees. The original utilization review (10-21-15) denied a request for a caudal epidural steroid injection lumbar spine.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Caudal epidural steroid injection lumbar spine:** 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), Neck and Upper Back, online version, epidural steroid injection.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): General Approach, Initial Care, Summary, and Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation American Society of Interventional Pain Physician: Comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations.

**Decision rationale:** The best medical evidence today for individuals with low back pain indicates that having the patient return to normal activities provides the best outcomes. Therapy should be guided, therefore, with modalities that will allow this outcome. Epidural steroid injections are an optional treatment for pain caused by nerve root inflammation as defined by pain in a specific dermatome pattern consistent with physical findings attributed to the same nerve root. As per the MTUS the present recommendations are for no more than 2 such injections, the second being done only if there is at least a partial response from the first injection. Its effects usually will offer the patient short-term relief of symptoms, as they do not usually provide relief past 3 months, so other treatment modalities are required to rehabilitate the patient's functional capacity. The American Society of Interventional Pain Physicians (ASIPP) found limited evidence for accuracy of diagnostic nerve blocks but recommends diagnostic selective nerve root blocks in the lumbar spine in select patients with an equivocal diagnosis and involvement of multiple levels. Therapeutically, ASIPP noted good evidence for use of epidural steroid injections for managing disc herniation or radiculitis; fair evidence for axial or discogenic pain without disc herniation, radiculitis or facet joint pain with caudal and lumbar interlaminar epidural injections, and limited evidence with transforaminal epidural injections. The MTUS provides very specific criteria for use of this therapy. Specifically, the presence of a radiculopathy documented by examination and corroborated by imaging, and evidence that the patient is unresponsive to conservative treatment. For this patient there is suggestive documentation on history and examination of the radicular nature of the patient's symptoms and lumbar MRI does describe discogenic abnormalities. The records also document the patient is unresponsive to conservative therapy (medications and physical therapy). Thus the patient does meet the criteria for this procedure at this time. Medical necessity has been established. The request is medically necessary.