

<b>Case Number:</b>	CM15-0059974		
<b>Date Assigned:</b>	04/06/2015	<b>Date of Injury:</b>	01/22/2011
<b>Decision Date:</b>	05/05/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/30/2015

### 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, Hawaii

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 42 year old male, who sustained an industrial injury on 1/22/2011. Diagnoses include low back pain, L4-5 disc space narrowing status-post L4-5 decompression and instrumented fusion (10/28/2013), sacralization of L5 and status-post L4-5 microdiscectomy. Treatment to date has included surgical intervention diagnostics, epidural steroid injection, physical therapy, aqua therapy and medications. Per the Primary Treating Physician's Progress Report dated 1/15/2015, the injured worker reported low back and thigh pain. He reports that his symptoms are improving overall. Physical examination revealed reflexes at the knees and ankles 1+. Range of motion testing has not been completed due to recent surgery. The plan of care included medications and follow up care. Authorization was requested for right lumbar transforaminal epidural steroid injection at L4-5 under fluoroscopy and a pain management consultation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 RIGHT LUMBAR TRANSFORAMINAL EPIDURAL STEROID INJECTION AT L4-L5 LEVELS UNDER FLUOROSCOPY:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 56.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs)  
Page(s): 46. 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." There were no medical documents provided to conclude that other rehab efforts or home exercise program is ongoing. Additionally, no objective findings were documented to specify the dermatomal distribution of 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 is documented with imaging studies. The treatment notes do indicate other conservative treatments were tried and failed (exercises, physical therapy, etc). As such, the request for 1 RIGHT LUMBAR TRANSFORAMINAL EPIDURAL STEROID INJECTION AT L4-L5 LEVELS UNDER FLUOROSCOPY is medically necessary.