

<b>Case Number:</b>	CM15-0083430		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	10/09/2009
<b>Decision Date:</b>	06/10/2015	<b>UR Denial Date:</b>	04/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2015

### 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: California  
 Certification(s)/Specialty: Internal 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:

This is a 58 year old male with an October 9, 2009 date of injury. At the time (April 21, 2015) of the most recent evaluation submitted for review, there is documentation of subjective findings (pain rated at a level of 6/10; increasing pain over the previous year, becoming more painful in the past three months; pain that radiates down the low back down the posterolateral thigh and calf wrapping around and including the dorsum of the foot and middle toes; loss of sensation is affected area and numbness and tingling of the affected limb(s)), objective findings (lumbar discomfort with flexion; negative straight leg raise; absent patellar reflexes bilaterally; normal ankle jerk reflexes; tenderness to compression over the lower lumbar segments bilaterally; normal gait; spinal tightness noted; positive straight leg raises bilaterally; full reflexes and motor power noted for reduces EHL power bilaterally; sensory reduction over the L5 dermatome bilaterally), current diagnoses (lumbar or lumbosacral disc degeneration; lumbago; cervical disc degeneration; brachial neuritis or radiculitis not otherwise specified), and treatments to date (cervical epidural injection, lumbar selective nerve root block, anti-inflammatory medications, lumbar decompression). The medical record identifies that medications help control pain, and that the injured worker had tried and failed conservative therapies such as simple analgesics and physical therapy. The treating physician documented a plan of care that included transforaminal epidural steroid injection of the lumbosacral spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Transforaminal Epidural Steroid Injection (TFESI), (lumbosacral) L5-S1:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page 46.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses epidural steroid injections (ESIs). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 300) states that invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Epidural steroid injections treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Chronic Pain Medical Treatment Guidelines (Page 46) states that epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The American Academy of Neurology concluded that epidural steroid injections do not affect impairment of function or the need for surgery and do not provide long-term pain relief. ESI treatment alone offers no significant long-term functional benefit. Criteria for the use of epidural steroid injections requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. Most current guidelines recommend no more than 2 ESI injections. No more than 2 epidural steroid injections are recommended. Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. Magnetic resonance imaging MRI of the lumbar spine performed on 11-23-2009 documented advanced degenerative disc disease and hypertrophic changes in the posterior elements at L4-5 causing bilateral foramina stenosis and right lateral recess stenosis. Degenerative disc disease at L3-4 without significant central stenosis and mild bilateral lateral recess stenosis was noted. At L4-5, there is degenerative disc disease and hypertrophic changes involving the facet joints. There is bilateral neural foraminal stenosis and right lateral recess stenosis. No central stenosis. At L5-S1, no disc herniation or encroachment upon the central canal or neural foramina was. There are degenerative changes in the facet joints. The operative report dated April 9, 2010 documented bilateral L3-4, L4-5 interlaminar decompression with hemi-laminotomies, partial medial fasciectomy and foraminotomies. Postoperative diagnosis was lumbar spinal stenosis L3-4, L4-5. The pain medicine progress report dated April 21, 2015 noted that there was a normal MRI at L5-S1 in the past. The patient had lumbar decompression surgery in 2010, and the MRI would not be relevant, and should another MRI be recommended, then the treating physician would order another MRI. The physician desired to proceed with a selective nerve root block at the L5-S1 segment bilaterally, rather than undergoing another imaging study. The treatment plan included a request for bilateral L5-S1 transforaminal epidural injections. The treating physician noted that there was a normal MRI at L5-S1 in the past. Treating physician indicated that an updated MRI had not been performed. In the 4/21/15 progress report, the treating physician indicated that the previous

MRI was performed before the lumbar spine surgery in 2010, and would not be currently relevant. The MTUS criteria for the use of epidural steroid injections requires that radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. Because there are no corroborating imaging studies, the request for bilateral L5-S1 epidural injections is not supported by MTUS criteria. Therefore, the request for bilateral L5-S1 transforaminal epidural injections is not medically necessary.