

<b>Case Number:</b>	CM15-0231333		
<b>Date Assigned:</b>	12/07/2015	<b>Date of Injury:</b>	04/10/2012
<b>Decision Date:</b>	01/11/2016	<b>UR Denial Date:</b>	10/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/24/2015

### 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 63 year old male, who sustained an industrial injury on 04-10-2012. A review of the medical records indicates that the worker is undergoing treatment for lumbar radiculopathy, plantar fascial fibromatosis and other hammer toe (s) (acquired), left foot. Treatment has included Lyrica. MRI of the lumbar spine on 07-07-2014 was noted to be positive for focal findings and to show granulation tissue impinging on the L5 and S1 nerve roots. MRI of the lumbar spine dated 06-08-2015 was noted to show resolution of the previously identified area of recurrent disc herniation. The orthopedist indicated that surgery was not recommended and that the worker would benefit from epidural at L4-L5 on the right. In an orthopedic consultation on 08-03-2015, the worker was reporting pain in the right side of the lower back with occasional pain on the left side of the lower back and numbness in the bilateral feet. Objective findings showed weakness of toe raise, decreased sensory findings in the lateral aspect of the right leg, weakness of tibialis anterior and motor testing and positive straight leg raising reproducible of back and leg pain. Subjective complaints (09-04-2015 and 10-16-2015) included pain in the right low back radiating to the posterior right leg with paresthesias of the right leg and foot in a nerve root distribution. Objective findings revealed moderate pain to palpation of the right sacroiliac joint and right paralumbar muscles and moderately restricted range of motion due to pain. Objective findings (10-16-2015) included an antalgic gait, slight to moderate pain to palpation of the right paraspinal muscles of the low back and equivocal muscular spasm with palpation of the back. The physician noted that the worker's symptoms were not improving and that the worker had persistent subjective complaints suggestive of radiculopathy. A request for

epidural steroid injection at the L4-L5 level on the right side was submitted. A utilization review dated 10-26-2015 non-certified a request for 1 right epidural steroid injection at the L4-L5 level.

## **IMR ISSUES, DECISIONS AND RATIONALES**

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

### **1 Right epidural steroid injection at the L4-L5 level: 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: "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 electro-diagnostic 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 electro-diagnostic 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 9/4/15 and 10/16/15 do not demonstrate a failure of conservative management nor a clear evidence of a dermatomal distribution of radiculopathy. Per CA MTUS guidelines radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing. As the MRI shows no nerve root compression the guidelines for an ESI have not been met. Therefore the proposed epidural steroid injection is not medically necessary.