

<b>Case Number:</b>	CM15-0011162		
<b>Date Assigned:</b>	02/18/2015	<b>Date of Injury:</b>	12/06/2010
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	12/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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: Arizona, California  
 Certification(s)/Specialty: Family Practice

### 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 68 year old male who sustained an industrial injury on December 6, 2010. He has reported left lower back pain with left L5 numbness and tingling and left leg weakness and has been diagnosed with multilevel lumbar disc disease with grade 1 spondylolisthesis at L5-S1 and left L5 radiculopathy, L3-L4, L4-L5 and L5-S1 moderate central narrowing with L3-L4 and L4-L5 moderate bilateral foraminal narrowing, lumbar facet syndrome with overlying myofascial pain, bilateral shoulder injury, left knee meniscal tear, high grade chondral degeneration with a long central trochlea and a moderate size popliteal cyst, left sacroiliac joint dysfunction, and right hip pain. Treatment has included medical imaging and medications. Currently the injured worker showed motor strength as diminished on the left tibials anterior at 4+/5 compared to the right with diminished sensation along the left L5 dermatomal distribution with positive straight leg raise and positive Patricks maneuver. The treatment plan included lumbar epidural steroid injection. On December 19, 2014 Utilization Review non certified left transforaminal epidural steroid injection L4,L5 citing the MTUS guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left transforaminal epidural steroid injection L4, L5:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines  
[www.ncbi.nlm.nih.gov](http://www.ncbi.nlm.nih.gov)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG and Low back chapter- ESI

**Decision rationale:** According to the ACOEM guidelines, epidural steroid injections are not recommended. Invasive techniques are of questionable merit. Epidural Steroid Injections may provide short-term improvement for nerve root compression due to a herniated nucleus pulposus. The treatments do not provide any long-term functional benefit or reduce the need for surgery. According to the ODG guidelines, the criteria for epidural injections is: Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. (1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be 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) and injection of contrast for guidance. (4) Diagnostic Phase: At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be 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. In addition the ODG guidelines considers it an option for short-term pain relief. In this case, the claimant has had previous injections with 5 months ago with relief. In addition the request was not under fluoroscopy. Based on the guidelines and clinical information, the request for additional epidural injections is a short-term option but not considered a medical necessity.