

<b>Case Number:</b>	CM15-0012896		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	04/14/2010
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	01/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/22/2015

### 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:

The injured worker is a 34 year old male, who sustained an industrial injury on 4/14/2010. The diagnoses have included displacement of lumbar intervertebral disc without myelopathy, lumbar spine facet syndrome at L3 through S1, neuropathic pain and status-post L5-S1 fusion in progress with L4-5 (Prodisc) disc replacement (5/03/2011 and 5/04/2011). Treatment to date has included medications, activity modification and epidural steroid injection. Currently, the IW complains of worsening back pain. Objective findings included an improved gait but he still has to use his cane intermittently. There is pain to palpation over the facet joints at L4-5 and L5-S1. There is limited extension secondary to facet pain. Straight leg raise is positive at 90 degrees. Faber was positive on the left indicating sacroiliitis. X-rays of the lumbar spine dated 4/24/2014 showed L5-S1 fused well. Computed tomography (CT) scan of the lumbar spine dated 5/24/2013 showed mild annular disc bulge at L3-4, mild bilateral L5 spondylosis, postsurgical changes and no spondylolisthesis. There is no focal disc protrusion, spinal, or foraminal stenosis. On 1/14/2015, Utilization Review non-certified a request for bilateral L3-4, L4-5, L5-S1 transforaminal epidural steroid injection (ESI) noting that the clinical information submitted for review failed to meet the evidence based guidelines for the requested service. The MTUS and ACOEM Guidelines were cited. On 1/22/2015, the injured worker submitted an application for IMR for review of bilateral L3-4, L4-5, L5-S1 transforaminal epidural steroid injection (ESI).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral L3-4, L4-5, L5-S1 Transforaminal Epidural Steroid Injections with Fluoroscopy:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Transforaminal Epidural Steroid Injection 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. The progress report dated 12/22/14 did not document radiculopathy on physical examination. The progress report dated 12/16/14 did not document radicular pain. Radiculopathy was not documented on physical examination. Per MTUS, radiculopathy must be documented by physical examination. Because radiculopathy was not demonstrated, epidural steroid injections are not supported by MTUS guidelines. Therefore, the request for lumbosacral epidural steroid injections is not medically necessary. No imaging studies or electrodiagnostic testing were documented. Per MTUS, the use of epidural steroid injections requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and electrodiagnostic testing. Utilization review determination letter dated 01/14/15 documented that the treating physician stated that the request for epidural injections was made in error. The request for lumbosacral epidural steroid injections is not supported by the medical records or MTUS guidelines. Therefore, the request for lumbosacral epidural steroid injections is not medically necessary.