

<b>Case Number:</b>	CM15-0122922		
<b>Date Assigned:</b>	07/07/2015	<b>Date of Injury:</b>	09/22/2000
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	06/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2015

### 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: North Carolina  
 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 (IW) is a 61-year-old female who sustained an industrial injury on 09/22/2000. Diagnoses include lumbago; degeneration of lumbar intervertebral disc; spinal stenosis at lumbar region without neurogenic claudication; and lumbar facet joint pain. Treatment to date has included medications, bracing, epidural steroid injections (ESI), acupuncture, physical therapy (PT), sacroiliac joint (SIJ) injections, medial branch nerve blocks (MBB) and radiofrequency nerve ablations (RFA). The IW indicated PT with acupuncture worked best for her. According to the progress notes dated 6/2/15, the IW reported her back was still bothering her. She was also distraught due to her disability insurance cancellation. She was depressed. On examination, she was very uncomfortable and did not sit down; she was constantly moving. Unsupported SI flexion was painful. There was tenderness to the obliques, iliacus and psoas; just central to the ischial tuberosity; and to the symphysis pubis. Straight leg raise was mildly positive on the left with pulling hamstring. Lumbar spine MRI findings from 4/14/15 were multilevel degenerative disc disease, worse at L2-3 on the right. A request was made for right L2-3 and left L4-5 and L5-S1 epidural steroid injections; guidance of local needle; epidurography; and conscious sedation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right L2-L3 and Left L4-L5-S1 epidural steroid injections, guidance of local needle and epidurography: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Eur Spine J. 2010 Sep; 19(9): 1479-83. doi:10. 1007/s00586-010-1469-8. Epub 2010 May 29. Caudal epidurals: the accuracy of blind needle placement and the value of a confirmatory epidurogram. Barham G, Hilton A. Source Spinal Surgery Service, Orthopaedic Department, Dorset County Hospital NHS, Foundation Trust, Dorset County Hospital, Williams Avenue, Dorchester, Dorset DT1 2JY, UK guybarham1@aol. com.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46.

**Decision rationale:** The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: 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. The provided clinical documentation shows the patient has had previous ESI without a documented 50 % reduction in pain lasting 6-8 weeks with a medication usage reduction. Therefore, the request is not medically necessary.

**Conscious Sedation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46.

**Decision rationale:** The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: 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. The provided clinical documentation shows the patient has had previous ESI without a documented 50 % reduction in pain lasting 6-8 weeks with a medication usage reduction. As the ESI is not medically warranted, the need for conscious sedation is not medically necessary. Therefore the request is not certified.