

<b>Case Number:</b>	CM15-0170766		
<b>Date Assigned:</b>	09/11/2015	<b>Date of Injury:</b>	04/03/2012
<b>Decision Date:</b>	10/09/2015	<b>UR Denial Date:</b>	08/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/31/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 41 year old female, who sustained an industrial injury on 4-3-2012. The current diagnoses are low back pain and lumbar radiculopathy. According to the progress report dated 8-28-2015, the injured worker complains of pain in her bilateral legs and persisting pain in the right buttocks. The level of pain is not rated. The physical examination reveals mild, mid lower back pain to palpation, decreased flexion due to pain, and decreased left patellar deep tendon reflexes. The current medications are Flector patch, Norco, Ibuprofen, Metaxalone, and Lutera. Treatment to date has included medication management, x-rays, home exercise program, MRI studies, electrodiagnostic testing, and radiofrequency medial branch neurotomy at right L3, L4, and L5 (6-30-2015). MRI shows broad-based posterior disc herniation, L3-L4 with mild effacement of the anterior aspect of the thecal sac and segmental narrowing. There is minimal mass effect upon the nerve roots within the thecal sac. Mild facet joint degeneration is demonstrated at the lower lumbar levels. Work status is not specified. A request for physical therapy and lumbar epidural steroid was submitted. The original utilization review (8-31-2015) had non-certified a request for bilateral transforaminal epidural steroid injections L3-L4.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transforaminal epidural steroid injection bilateral L3 qty:1: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** The claimant sustained a work injury in April 2012 and is being treated for low back pain with bilateral lower extremity radicular symptoms. An MRI of the lumbar spine is referenced as showing a broad based disc herniation with mild bilateral narrowing. Bilateral lumbar transforaminal epidural steroid injections were done in December 2014. In February 2015 there had been slight benefit. When seen, there had been improvement after a recent right radiofrequency ablation treatment. She was having more radicular symptoms bilaterally. Physical examination findings included positive right straight leg raising with decreased L3 and L4 sensation bilaterally. There was an absent left patellar reflex. A second epidural steroid injection was requested. In terms of lumbar epidural steroid injections, guidelines recommend that, in the diagnostic phase, a maximum of two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block. A second block is also not indicated if the first block is accurately placed unless there is a question of the pain generator, there was possibility of inaccurate placement, or 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. In this case, the claimant had at least partial benefit from the injection done in November 2014. She has radicular pain and physical examination findings are consistent with bilateral lumbar radiculopathy. A second epidural steroid injection can be considered medically necessary.

**Transforaminal epidural steroid injection bilateral L4 qty:1:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** The claimant sustained a work injury in April 2012 and is being treated for low back pain with bilateral lower extremity radicular symptoms. An MRI of the lumbar spine is referenced as showing a broad based disc herniation with mild bilateral narrowing. Bilateral lumbar transforaminal epidural steroid injections were done in December 2014. In February 2015 there had been slight benefit. When seen, there had been improvement after a recent right radiofrequency ablation treatment. She was having more radicular symptoms bilaterally. Physical examination findings included positive right straight leg raising with decreased L3 and L4 sensation bilaterally. There was an absent left patellar reflex. A second epidural steroid injection was requested. In terms of lumbar epidural steroid injections, guidelines recommend that, in the diagnostic phase, a maximum of two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block. A second block is also not indicated if the first block is accurately placed unless there is a question of the pain generator,

there was possibility of inaccurate placement, or 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. In this case, the claimant had at least partial benefit from the injection done in November 2014. She has radicular pain and physical examination findings are consistent with bilateral lumbar radiculopathy. A second epidural steroid injection can be considered medically necessary.