

<b>Case Number:</b>	CM15-0082552		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	02/18/2000
<b>Decision Date:</b>	10/05/2015	<b>UR Denial Date:</b>	04/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, 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 52 year old female, who sustained an industrial injury on 2-18-2000. The injured worker was diagnosed as having lumbar degenerative disc disease and lumbago. Treatment to date has included diagnostics, left carpal tunnel release in 8-2013, bilateral L5-S1 transforaminal injection on 2-02-2015, physical therapy, and medications. Currently (4-14-2015), the injured worker complains of severe and worsening back pain with radiation into her upper thighs. She was quite distress and expressed that she could not go on with this level of pain. She reported switching from MS Contin to another opioid, due to side effect of "acting strange" in the middle of the night. She reported the sensation of feces coming out at all times and water dripping down her leg sensation. She also noted worsening genital numbness in the past 6 weeks, causing her to seek care in the Emergency Department (ED). A Toradol injection was administered in the ED and was ineffective. She was unable to complete activities of daily living and required assistance from her spouse for bathing and toileting. Neurological exam noted diminished sensation in a L4-S1 bilateral dermatomal distribution and absent Achilles deep tendon reflex bilaterally. Musculoskeletal exam noted limited lumbar range of motion, tenderness to palpation over the paraspinal muscles overlying the facet joints and sacroiliac joints on both sides, and positive bilateral straight leg raise. Weakness was noted to the bilateral extensor hallucis longus muscles. She was unable to heel or toe walk, unable to perform a deep knee bend, and had extreme difficulty with repositioning on exam table-chair. The treatment plan included a L5-S1 epidural steroid injection. No improvement was documented following the previous epidural steroid injection in 2-2015.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **1 L5-S1 Lumbar Epidural Steroid Injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESIs Epidural Steroid Injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

**Decision rationale:** Per the MTUS CPMTG epidural steroid injections are used 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 benefit. The criteria for the use of epidural steroid injections are as follows: 1) Radiculopathy must be documented by physical examination and 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) 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. Per progress report dated 4/14/15, physical exam noted absent Achilles reflex bilaterally, diminished sensation to pinprick in the L4, L5, and S1 dermatomal distribution, and bilateral extensor hallucis longus weakness. Imaging studies were not available for review, however, it was noted that the injured worker had marked disc disruption at L3-L4 by MRI. It was noted that the injured worker previously was treated with ESI in 2/2015, however, there was no documentation of efficacy. Absent this documentation, the medical necessity of repeat ESI cannot be affirmed.