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| <b>Case Number:</b>   | CM13-0002360 |                              |            |
| <b>Date Assigned:</b> | 12/27/2013   | <b>Date of Injury:</b>       | 09/18/2011 |
| <b>Decision Date:</b> | 02/20/2014   | <b>UR Denial Date:</b>       | 07/08/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/22/2013 |

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 36-year-old female who reported an injury on 09/18/2011 due to a motor vehicle accident. The patient complained of cervical, thoracic, lumbar spine and bilateral hip pain. Prior treatments included physical therapy, injection therapy, medications, and home exercise program. The patient's most recent clinical evaluation revealed positive impingement sign in the bilateral hips, positive left-sided straight leg raising test, no neurological deficits, and a negative Faber's test of the hips bilaterally. Additional treatments included acupuncture, chiropractic care, and psychological support. The patient's treatment plan included continuation of psychological support, additional lumbar epidural steroid injection, and continuation of acupuncture.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Repeat Bilateral L5 and Left L4 Trans foraminal Lumbar Epidural Injection:** Upheld

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

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

**Decision rationale:** The requested repeat bilateral L5 and left L4 transforaminal epidural steroid injections are not medically necessary or appropriate. California Medical Treatment Utilization

Schedule recommends that repeat injections be based on pain relief rated at, at least, 50% and documentation of significant functional improvement for approximately 6 to 8 weeks. The clinical documentation submitted for review does provide evidence that the patient previously received an epidural steroid injection at the requested level. However, a quantitative assessment of pain relief, or documentation of functional benefit was not documented. Therefore, an additional epidural steroid injection would not be indicated. As such, the requested repeat bilateral L5 and left L4 transforaminal lumbar epidural steroid injections are not medically necessary or appropriate.