

<b>Case Number:</b>	CM13-0026510		
<b>Date Assigned:</b>	06/06/2014	<b>Date of Injury:</b>	10/01/2006
<b>Decision Date:</b>	07/28/2014	<b>UR Denial Date:</b>	08/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2013

### 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. The expert reviewer is Board Certified in Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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/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 injured worker is a 41-year-old male who reported an injury on 10/01/2006, secondary to an unspecified mechanism of injury. The injured worker was evaluated on 12/10/2013, for reports of right sided low back pain. Exam noted the injured worker had a right sided L4-5 ESI, on 08/28/2013, which provided 70% relief for 3 to 4 weeks. The injured worker reported current pain level at 7/10 with 50% functionality. The exam noted neck, muscle, and low back pain with stiffness. The exam also noted pain radiating down arm and leg with numbness, tingling, and burning. The exam further noted a normal sensory exam with a negative straight leg raise noted. The diagnoses included chronic mechanical low back pain with radicular features, lumbar spondylosis and disc protrusion at L4-5. The treatment plan included an epidural steroid injection to the left. The request for authorization, dated 12/10/2013, was found in the documentation provided. The rationale for the request, noted in the office notes, was due to the injured worker's pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right L4-5 transforaminal ESI QTY: 1.00:** Upheld

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

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

**Decision rationale:** The request for right L4-5 transforaminal ESI, QTY 1, is non-certified. The California MTUS Guidelines may recommend epidural steroid injections as an option for treatment of radicular pain, to reduce pain and inflammation, restore range of motion and thereby facilitating progress in more active treatment progress and avoiding surgery. The guidelines further state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The injured worker should be initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs, and muscle relaxants). Injections should be performed using fluoroscopy for guidance. If used for diagnostic purposes, a maximum of 2 injections should be performed. There is a significant lack of clinical evidence in the documentation provided of pain, radicular in nature, with corroboration by imaging studies. There is also a significant lack of clinical evidence in the documentation provided of the injured worker's trials of conservative methods and their efficacy. Furthermore, the request is for a right-sided epidural steroid injection; however, the clinical documentation provided recommends a left-sided epidural steroid injections. Therefore, due to the significant lack of objective clinical findings of pain, radicular in nature, which has been corroborated by imaging or electrodiagnostic studies, the lack of documentation of failed conservative therapies and the request being for the right side and the clinical notes recommending a left sided injection, the request for right L4-5 transforaminal ESI, QTY 1, is non-certified.

**FLUOROSCOPIC GUIDANCE QTY: 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.