

<b>Case Number:</b>	CM13-0042179		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	07/05/1993
<b>Decision Date:</b>	04/09/2014	<b>UR Denial Date:</b>	09/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/17/2013

### 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 Internal Medicine, has a subspecialty in Rheumatology and is licensed to practice in New York. 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 62 year old man who was injured in 1993. His diagnoses are lumbar spinal stenosis, cervicalgia, status post right total knee replacement, left shoulder tendinopathy, right knee suture abscess, chronic pain disorder, and major depression. There is also a history of right hip pain with a diagnosis of avascular necrosis of the femoral head. The requested procedure is a translaminar lumbar epidural corticosteroid injection. The medical records document back pain and pain in both lower extremities, as well as pain in the left shoulder. There is marked limitation of motion in the lower back. Range of motion in the left shoulder is restricted. The patient requires narcotic medication to control his pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 TRANSLAMINAR LUMBAR EPIDURAL STEROID INJECTION: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Table 2.

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

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, page 46, epidural steroid injections are "recommended as an option for treatment of radicular pain,

defined as pain in dermatomal distribution with corroborative findings of radiculopathy." The criteria for use of epidural steroid injections specify that "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." The medical records document back pain and limitation of range of motion on physical exam, but the records do not document radiculopathy. There are no imaging studies of the lumbosacral spine. Results of electrodiagnostic testing are not provided. Therefore, the requested treatment does not satisfy the MTUS criteria and is not medically necessary.