

<b>Case Number:</b>	CM13-0064417		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	08/01/2009
<b>Decision Date:</b>	04/21/2014	<b>UR Denial Date:</b>	11/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/11/2013

### 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 Internal Medicine, Pulmonary Diseases and is licensed to practice in California. 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 patient is a 59-year-old female who reported injury on 08/01/2009. The mechanism of injury was not provided. The office note dated 10/31/2013 revealed the patient had a left-sided L4-5 interlaminar decompression with hemilaminectomy, partial medial facetectomy and foraminotomy at L4-5 on 07/21/2010. It was indicated that the patient's pain was reduced from 7/10 to 4/10 with the current treatment. The MRI was noted to have been reviewed and revealed a recurrent left L5 compression. The patient indicated that the quality of life improvement score was 80% with current treatment. The activities of daily living improvement score was 60% with treatment. The physical examination revealed a decreased sensation to pinprick on the left at L5 and a positive straight leg raise at 45 degrees on the left. The request was made for a lumbar epidural steroid injection. The patient's diagnoses were noted to be intervertebral disc disorders and displacement of the thoracic or lumbar intervertebral disc without myelopathy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LUMBAR EPIDURAL STEROID INJECTION:** Upheld

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

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

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines indicate that for the use of an epidural steroid injection there should be documentation of objective findings of radiculopathy upon physical examination, corroboration with an MRI or electrodiagnostic studies and documentation that the patient had failed conservative therapy. The clinical documentation submitted for review indicated the patient had objective findings of radiculopathy upon physical examination, and that the pain had not improved with conservative care. The official MRI was not provided for review. The request as submitted failed to indicate the level and laterality for the lumbar epidural steroid injection. The request for a lumbar epidural steroid injection is not medically necessary and appropriate.