

<b>Case Number:</b>	CM14-0100308		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	05/16/2000
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	06/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine 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 records presented for review indicate that this 56 year-old female was reportedly injured on May 16, 2000. The most recent progress note, dated May 9, 2014, indicates that there were ongoing complaints of low back pain with radiation into the right buttock, right lateral thigh and posterior calf with subjective numbness, paresthesias, and weakness. The physical examination demonstrated paralumbar spasms and 2+ tenderness to palpation on the right. Atrophy was noted in the quadriceps. Range of motion was restricted. Straight leg raise was positive on the right. Motor strength was 5/5 in all groups bilaterally. Diagnostic studies objectified revealed no evidence of acute lumbar radiculopathy. An MRI of the lumbar spine on May 25, 2010 revealed at L3-L4 annular tear/Fisher, and facet arthropathy with a 3 mm anterior disc protrusion. At L4-5, facet arthropathy was noted. There was no compromise of the exiting nerve roots at either L4-5 or L5-S1. An MRI from November 2012 revealed minimal diffuse disc bulging, moderate to severe degenerative facet arthropathy at L4-5 on the right, a synovial cyst from the posterior margin of L3-4 left facet joint, and no evidence of central canal or foraminal stenosis. Prior treatment has included physical therapy, pharmacotherapy, activity modification, and cold and heat therapy. A request had been made for right L4-L5, and L5-S1 transforaminal steroid injection with monitored anesthesia and epidurography and was not certified in the pre-authorization process on June 3, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right L4-L5, L5-S1 transforaminal steroid injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) : Epidural Steroid Injection

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

**Decision rationale:** MTUS guidelines support epidural steroid injections when radiculopathy is documented on physical examination and corroborated by imaging and electrodiagnostic studies in individuals who have not improved with conservative care. Based on the clinical documentation provided, and considering the criteria for the use of epidural steroid injections as outlined in the MTUS, there is insufficient clinical evidence presented that the proposed procedure meets the MTUS guidelines. Specifically, there is no documentation of imaging and/or electrodiagnostic studies to support the physical exam findings of a radiculopathy. As such, the requested procedure is deemed not medically necessary and is recommended for non-certification.

**Monitored anesthesia care:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Monitored Anesthesia Care (MAC)

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

**Decision rationale:** While the guidelines would support this request as a necessary part of the proposed procedure, the proposed procedure under review has not been determined to be medically necessary. In the absence of that, procedure, monitored anesthesia services would not be medically necessary.

**Epidurography:** Upheld

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

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

**Decision rationale:** While the guidelines would support this request as a part of the proposed procedure, the proposed procedure under review has not been determined to be medically necessary. In the absence of that procedure, the proposed epidurography would not be medically necessary.