

<b>Case Number:</b>	CM14-0101015		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	02/05/2004
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	06/17/2014
<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 and is licensed to practice in Nevada. 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 60 year-old individual was reportedly injured on 2/5/2004. The mechanism of injury is not listed. The most recent progress note, dated 6/2/2014. Indicates that there are ongoing complaints of low back pain that radiates down left lower extremity. The physical examination demonstrated lumbar spine: positive tenderness to palpation midline right paraspinal muscles, left paraspinal muscles, and right side sacroiliac joint. Straight leg raise test is positive on the left side of 35 on the right. Range of motion is decreased and limited by pain. Sensation is decreased in the L4, 5, and S1 distribution on the left by approximate 40% compared to the right side. Motor is intact bilaterally. No recent diagnostic studies are available for review. Previous treatment includes medications, lumbar epidural steroid injections, and conservative treatment. A request had been made for lumbar epidural steroid injection level unspecified and was not certified in the pre-authorization process on 6/17/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar Epidural Steroid Injection (specific site unknown): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Epidural Steroid Injections.

**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, there is insufficient clinical evidence that the proposed procedure meets the MTUS guidelines. Specifically, there is no documentation of reduction in pain from previous injections. As such, the requested procedure is not medically necessary.