

<b>Case Number:</b>	CM14-0104002		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	05/05/2011
<b>Decision Date:</b>	11/14/2014	<b>UR Denial Date:</b>	06/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2014

### 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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 57-year-old female with a 5/5/11 date of injury. At the time (6/2/14) of request for authorization for Pain Management Evaluation & treatment with possible epidural injection, there is documentation of subjective (lower back pain with radiating pain into her right lower extremity) and objective (tenderness on palpation of the paravertebral muscles in the lower lumbar region, limited lumbar spine range of motion in all plains, positive straight leg test on the right, and positive Bragard's test on the right) findings, imaging findings (reported MRI lumbar spine (unspecified date) revealed intervertebral disc disorder of the lumbar spine; report not available for review), current diagnoses (intervertebral disk disorder of the lumbar spine and lumbar radiculitis/radiculopathy), and treatment to date (medications and physical therapy).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pain Management Evaluation & Treatment with Possible Epidural Injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations

and consultations 127 Official Disability Guidelines (ODG) Low Back, Epidural Steroid Injections (ESIs)

**Decision rationale:** Specifically regarding the pain management evaluation, MTUS reference to ACOEM guidelines identifies that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work, as criteria necessary to support the medical necessity to support the medical necessity of consultation. Specifically regarding treatment with possible epidural injection, MTUS reference to ACOEM Guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, failure of conservative treatment (activity modification, medications, and physical modalities), and no more than two nerve root levels injected one session; as criteria necessary to support the medical necessity of lumbar transforaminal epidural steroid injection using fluoroscopy. Within the medical information available for review, there is documentation of diagnoses of intervertebral disk disorder of the lumbar spine and lumbar radiculitis/radiculopathy. In addition, there is documentation of failure of conservative treatment (activity modification, medications, and physical modalities). However, despite documentation of subjective (lower back pain with radiating pain into her right lower extremity) and objective (positive straight leg test on the right) findings, and given no documentation of the specific nerve root levels to be addressed, there is no documentation of subjective (pain, numbness, or tingling) and objective (sensory changes, motor changes, or reflex changes) radicular findings in what would be the specific levels to be addressed. In addition, despite documentation of the medical reports' reported imaging findings (MRI lumbar spine identifying intervertebral disc disorder of the lumbar spine), there is no documentation of an imaging (MRI, CT, myelography, or CT myelography & x-ray) report (nerve root compression or moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) in what would be the specific levels to be addressed. Therefore, based on guidelines and a review of the evidence, the request for Pain Management Evaluation & treatment with possible epidural injection is not medically necessary.