

<b>Case Number:</b>	CM14-0016533		
<b>Date Assigned:</b>	03/05/2014	<b>Date of Injury:</b>	06/24/2012
<b>Decision Date:</b>	04/25/2014	<b>UR Denial Date:</b>	01/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2014

### 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 & Rehabilitation and is licensed to practice in Illinois. 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:

This is a 67-year-old male patient with a date of injury 06/24/2012, and the mechanism of injury was not provided. A CT scan of the cervical spine on 07/24/2013 revealed some slight stenosis at C3-4 and some bony foraminal encroachment. A myelogram of the cervical spine on 07/24/2013 revealed anterior defects at C3-4, C4-5, C5-6, and C6-7. On 01/12/2014, the patient presented for a neurosurgical follow-up. The patient reported some neck pain as resolved; but then reported low back pain; bilateral buttock pain right greater than left; bilateral leg pain, intermittent; with right greater than left and bilateral leg aching. Medications listed as prescribed are Tramadol, Metformin, Trazodone, Hydrochlorothiazide, and occasionally, Ibuprofen. Objective findings were no cervical or thoracic paravertebral muscle spasm, the patient had a normal gait, deep tendon reflexes are symmetrical, and it was also noted that the patient had an epidural block in the cervical region in 03/2013, and the recommendation was for 2 more lumbar epidural steroid blocks.

### 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 INJECTIONS Page(s): 46.

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

**Decision rationale:** The CA MTUS Guidelines state "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit." The request for the lumbar epidural steroid injection is non-certified. The documentation submitted for review failed to include an MRI to corroborate radiculopathy, as well as any prior conservative treatments and patient's response. The CA MTUS Guidelines do recommend epidural steroid injections for radicular pain, when radiculopathy is corroborated by diagnostic imaging. Given that the documentation submitted for review did not provide a MRI study to support the request as well as response to other conservative care, such as the response to the epidural block in the cervical region in 03/2013, the request is non-certified.

**CONSULTATION FOR THE LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS AMERICA COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM) PAGE 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK.

**Decision rationale:** The CA MTUS/ACOEM Guidelines do not address. The Official Disability Guidelines state "The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible." The request for a consultation for the lumbar spine is non-certified. The documentation submitted for review did not provide a rationale for the consultation as well as any significant physical and neurological findings noted from the visit. The CA MTUS/ACOEM Guidelines do support consults or the office visit for evaluating and treating the patient; however, the documentation did not provide evidence to support the need for the consult. As such, the request is non-certified.