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| <b>Case Number:</b>   | CM14-0171760 |                              |            |
| <b>Date Assigned:</b> | 10/23/2014   | <b>Date of Injury:</b>       | 01/12/2010 |
| <b>Decision Date:</b> | 12/04/2014   | <b>UR Denial Date:</b>       | 10/02/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/17/2014 |

### 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 Occupational 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:

Patient is a 54 year-old male with date of injury 05/31/2009. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 08/26/2014, lists subjective complaints as pain in the low back. Objective findings: Examination of the lumbar spine revealed restricted range of motion in all planes due to pain, flexion being worse than extension. Lumbar discogenic provocative maneuver, sustained hip flexion, was positive bilaterally. Sacroiliac provocative maneuvers were negative bilaterally. Muscle stretch reflexes were 1 and symmetric bilaterally in all limbs. Clonus, Babinski's, and Hoffman's signs were absent bilaterally. Muscle strength was unchanged from the previous visits, except: right tibialis anterior, right extensor hallucis longus, and right gastrosoleus strength were 4+/5. Diagnosis: 1. Right L4 and right L5 radiculopathy with right lower extremity weakness 2. Lumbar disc protrusion 3. Lumbar stenosis 4. Bilateral internal knee derangement 5. Bilateral severe knee degenerative joint disease 6. Status post bilateral knee surgeries 7. Chronic knee pain 8. Chronic low back pain 9. Chronic bilateral shoulder pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transforaminal Epidural Steroid Injection Fluoroscopically Guided R L4-L5 and L-5--S1:**  
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:** According to the MTUS, several diagnostic criteria must be present to recommend an epidural steroid injection. The most important criteria are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. The medical record does not document a clear picture of radiculopathy on physical examination or on MRI. Transforaminal Epidural Steroid Injection Fluoroscopically Guided R L4-L5 and L5-S1 is not medically necessary.