

<b>Case Number:</b>	CM14-0026137		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	07/27/2011
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	02/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2014

### 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 Orthopedic Surgeon and is licensed to practice in Florida. 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 injured worker is a 46-year-old male who reported an injury on 07/27/2011. The injury sustained was to his lower back after heavy lifting. The injured worker's treatment history included physical therapy, medications, Functional Capacity Evaluation, pain management/psychological consultation, MRI, and physical therapy. The injured worker was evaluated on 10/23/2013 and it was documented that injured worker had on/off moderate low back pain that radiated down the left side more than the right leg with paresthesias. The provider noted that the injured worker complained of left groin pain that radiated to his testicles. Physical examination of the lumbar spine revealed tenderness to palpation of the lumbar paraspinals, and diminished range of motion of the lumbar spine. The straight leg raise test on the left was positive. There was no VAS scale measurements or medications listed for the injured worker. It was documented that the injured worker had undergone an MRI; however, findings was not submitted for this review. The diagnoses included left knee pain and mechanical symptoms, left knee chondromalacia, left knee S/P A/S, meniscectomy, microfracture, lumbar spinal strain, left lumbar radiculopathy, lumbar disc pathology, gastritis, and anxiety/depression. The request authorization for the epidural steroid injection was submitted on 08/12/2013; however, the rationale was not provided for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE REQUEST FOR BILATERAL L3 TO L4,L4 TO L5  
TRANFORAMINAL EPIDURAL STEROID INJECTION FLUROSCOPICALLY AND  
EPIDUROGRAM AND MAC DOS 12-10-13: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI.

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

**Decision rationale:** The California Treatment Guidelines recommend epidural steroid injections as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). The documents submitted on 10/23/2013 the injured worker was seen regarding his ongoing low back pain. The diagnoses included lumbar spinal strain, left lumbar radiculopathy, and lumbar disc pathology. The documents provided indicated the injured worker had undergone an MRI of the lower back; however, the findings were not submitted for review. There was lack of evidence of conservative care such as physical therapy and medication pain management. Therefore, given the above, the request for retrospective bilateral L3 -L5 transforaminal epidural steroid injection fluoroscopically and epidurogram and MAC (DOS: 12/10/2013) is not medically necessary.