

<b>Case Number:</b>	CM14-0028150		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	04/27/2013
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	03/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/05/2014

### 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 Neurology, has a subspecialty in Neuromuscular 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:

The patient is a 30-year-old man who sustained a work-related injury on April 27, 2013. He sustained chronic low back pain with radiation to the right lower extremity, diffuse numbness and paresthesias of the right leg, foot, and toes. Electrodiagnostic testing on December 12, 2013 revealed no evidence radiculopathy or peripheral neuropathy in the right lower extremity. MRI of the lumbar spine on June 4, 2013 revealed a small central disc protrusion with minimal clavicle extension of disc material in the midline compatible with contained herniation at the L5-S1 level. According to the progress report on February 26, 2014, the patient continues to have right sided thoracic and lumbar pain, which radiates to the right leg and right toe. The level of pain ranges from four out of ten to five out of ten in severity. He also reported numbness and tingling. His physical examination revealed lumbar tenderness with limited range of motion. The patient was reported to have negative straight leg raise bilaterally and intact sensation in the lower extremity. The patient received an epidural steroid injection on February 7, 2014 without significant improvement. He has been treated conservatively with acupuncture as well as physical therapy in addition to Lidoderm patches and non-steroidal anti-inflammatory medication. The patient was diagnosed with lumbar strain and nerve root irritation; L5-S1 disc protrusion; and clinical radiculopathy. The provider requested authorization for L5-S1 epidural steroid injections.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 EPIDURAL STEROID INJECTIONS #2: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** According to MTUS guidelines, epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit, however there is no significant long term benefit or reduction for the need of surgery. Furthermore, the patient file does not document that the patient is a candidate for surgery. The patient was treated with conservative therapy with no full control of the patients pain. Documentation does not contain objective findings on exam to support the presence of radiculopathy. Strength, sensation, and reflexes are noted to be intact. MTUS guidelines does not recommend epidural injections for back pain without radiculopathy. Furthermore, repeat epidural injection is considered only if there is at least 50% pain improvement after the first injection for at least six to eight weeks. In this case, the medical records did not report significant improvement from the first epidural injection. Therefore, L5-S1 Epidural Steroid Injection #2 is not medically necessary.