

<b>Case Number:</b>	CM14-0050833		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	08/01/2012
<b>Decision Date:</b>	08/21/2014	<b>UR Denial Date:</b>	04/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/18/2014

### 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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 40 year old male who sustained an industrial injury on 08/01/2012. The mechanism of injury was not provided for review. His diagnoses include chronic intractable low back pain, degenerative disc disease, disc herniation lumbar spine, radiculitis bilateral lower extremities, neuropathic pain, trochanteric bursitis of both hips, and depression. On exam there is tenderness to palpation over the paralumbar muscles and muscle guarding in the paralumbar musculature. Muscle strength was 5/5 in all muscle groups of the lower extremities. The lumbar range of motion was 30 degrees. Straight leg was positive bilaterally. There was diminished sensation over L4, L5, and S1 nerve root distribution. Hip examination showed tenderness to palpation over the greater trochanteric bursa bilaterally. Hip range of motion was normal. The treatment has included medical therapy and acupuncture. The treating provider has requested a lumbar epidural steroid injection.

### 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 injection Page(s): 46.

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

**Decision rationale:** There is no indication for a lumbar epidural steroid injection at this time. Per the guidelines, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing to substantiate the need for epidural injection. Epidural steroid Injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. The medical necessity for the requested lumbar steroid injection has not been established. The requested treatment is not medically necessary.