

<b>Case Number:</b>	CM14-0052570		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	07/11/2013
<b>Decision Date:</b>	08/18/2014	<b>UR Denial Date:</b>	04/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2014

### 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 and Rehabilitation 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 injured worker is a 51 year old male who reported an injury on 07/11/2013 due to cumulative trauma. On 04/03/2014, the injured worker presented with low back pain. He also reported complaints of radicular symptoms to the right lower extremity involving the right thigh, leg and ankle area. Upon examination, there was tenderness to palpation to the lumbar spinous process and bilateral SI joint, worse on the left side and a positive straight leg raise to the right at 45 degrees. Sensation was decreased to light touch from L4 to L5 and lumbar extension caused pain over the facet joints. The diagnoses were chronic low back pain with radicular symptoms to the right, and lumbar sprain/strain. Prior treatment included medications. The provider recommended a right interlaminar L4-5 ESI and a right interlaminar L5-S1 ESI and fluoroscopic guidance. The provider's rationale was not provided. The request for authorization was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Right Interlaminar L4-L5 Lumbar Epidural Steroid Injection x3: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use Of Epidural Steroid Injections (ESIs) Page(s): 46.

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

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend epidural steroid injections (ESI) as an option for treatment of radicular pain. An 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. There is no information on improved function. The criteria for use of an ESI include radiculopathy must be documented by physical examination and corroborated by imaging studies, be initially unresponsive to conservative treatment, injection should be performed using fluoroscopy for guidance, and no more than 2 levels should be injected using transforaminal blocks. The physical exam noted tenderness to palpation over the bilateral SI joint, a positive straight leg raise to the right, decreased sensation to light touch to the right L4-5, and tenderness to palpation over the lumbar spinous process, and infraspinal ligaments. Information would be needed as to motor strength deficits and tenderness over the specific facets. The included documents lack evidence of failure to respond to conservative treatment including physical therapy and medications. There is no corroboration of imaging studies with physical examination findings of radiculopathy. As such, the request is not medically necessary and appropriate.

**Right Interlaminar L5-S1 Lumbar Epidural Steroid Injection x3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use Of Epidural Steroid Injections (ESIs) Page(s): 46.

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

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend ESI as an option for treatment of radicular pain. An 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. There is no information on improved function. The criteria for use of an ESI include radiculopathy must be documented by physical examination and corroborated by imaging studies, be initially unresponsive to conservative treatment, injection should be performed using fluoroscopy for guidance, and no more than 2 levels should be injected using transforaminal blocks. The physical exam noted tenderness to palpation over the bilateral SI joint, a positive straight leg raise to the right, decreased sensation to light touch to the right L4-5, and tenderness to palpation over the lumbar spinous process, infraspinal ligaments and bilateral PSIS. Information would be needed as to motor strength deficits and tenderness over the specific facets. The included documents lack evidence of failure to respond to conservative treatment including physical therapy and medications. There is no corroboration of imaging studies with physical examination findings of radiculopathy. As such, the request is not medically necessary and appropriate.

**Fluoroscopic Guidance X3, Quantity 3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use Of Epidural Steroid Injections (ESIs) Page(s): 46.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.