MAXIMUS Federal Services

| Case Number: | CM14-0066067 | | |
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| Date Assigned: | 07/16/2014 | Date of Injury: | 03/29/2010 |
| Decision Date: | 09/17/2014 | UR Denial Date: | 05/05/2014 |
| Priority: | Standard | Application Received: | 05/08/2014 |

## 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 Rehabilitaion, has a subspecialty in Pain Management, and is licensed to practice in Texas and Ohio. 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 28-year-old who reported an injury on March 29, 2010. The mechanism of injury was noted to be a fall. Her diagnoses was noted to be a healed calcaneal fracture on the left and lumbar disc protrusion L4-5. Prior treatments were noted to be physical therapy and home exercise. Pertinent diagnostics were noted to be x-rays of the lumbar spine. She had an MRI that showed moderate dehydration and posterior bulging at L4-5. Her subjective complaints were increased low back pain and left leg pain. The objective findings were lumbar spasms with tightness and straight leg raise. Achilles reflexes were decreased compared to patella tendon reflex. Flexion at the waist was 70%. This primary treating physician's progress report does not include a treatment plan. The provider's rationale for the request was not noted and in addition, a Request for Authorization form was not provided within the review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar epidural steroid injection at left L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines CRITERIA FOR THE USE OF EPIDURAL STEROID INJECTIONS.

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

**Decision rationale:** The request for lumbar epidural steroid injection at left L5-S1 is non-certified. The Chronic Pain Medical 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). The purpose of an ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long term functional benefits. Criteria for use of an epidural steroid injection include radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Documentation must support failure of conservative treatment, including exercise, physical methods, NSAIDs (non-steroidal anti-inflammatory drugs), and muscle relaxants. Injections should be performed using fluoroscopy for guidance. The documentation provided for review does not meet the criteria for use of an epidural steroid injection according to the guidelines. The documentation does not provide an adequate neurological assessment. An official copy of an MRI to corroborate radiculopathy was not provided with the review. It was not noted that the injured worker had decreased strength and decreased sensation to a specific dermatome. Therefore, the request for a lumbar ESI at left L5-S1 is not medically necessary or appropriate.