

<b>Case Number:</b>	CM14-0086178		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	12/04/2002
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	05/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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 & 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 73-year-old female who reported an injury on 12/04/2002. The mechanism of injury was noted to be lifting a bed. Her diagnosis was noted to be neuralgia/neuritis and lumbago. Diagnostic testing includes x-ray of the right hip and lumbar spine. Prior treatments were noted to be injections, therapy and medications. The injured worker had a clinical evaluation on 02/20/2014. She had subjective complaints of right hip pain. The physical exam findings noted right hip had no deformity, erythema, soft tissue swelling, joint effusion, ecchymosis or gross atrophy. Palpation to the hip noted no tenderness, crepitation, warmth or palpable deformity. Range of motion to the hip with flexion was slightly decreased, hip and internal rotation was moderately decreased. Strength of the hip flexor was a 2/5. The treatment plan was for an x-ray of the lumbosacral spine, 4 views. In addition, the treatment plan included MRI of the lumbar spine without contrast. The provider's rationale for this request was not noted within the documentation submitted for review. A Request for Authorization form was not located within the documentation submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient lumbar transforaminal epidural steroid injection at the right L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Armon, 2007; Manchikanti, 2003; Boswell, 2007.

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

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines recommend an epidural steroid injection as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Criteria for the use of epidural steroid injections include radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Documentation must support failure of conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Injections should be used performed using fluoroscopy (live x-ray) for guidance. If used for diagnostic purposes, a maximum of 2 injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least 1 to 2 weeks between injections. No more than 2 nerve root levels should be injected using Transforaminal blocks. No more than 1 interlaminar level should be injected at 1 session. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks, with a general recommendation of no more than 4 blocks per region per year. The documentation submitted for review fails to indicate radiculopathy corroborated by imaging studies. In addition, the documentation fails to support failure of conservative treatment. The request fails to indicate fluoroscopy for guidance. An epidural steroid injection should be used in conjunction with other rehab efforts, including a home exercise program. This is not indicated within the documentation submitted for review. The clinical evaluation fails to provide an adequate neurological assessment. As such, the request for outpatient lumbar Transforaminal epidural steroid injection at the right L5-S1 is not medically necessary.