

<b>Case Number:</b>	CM15-0002289		
<b>Date Assigned:</b>	01/13/2015	<b>Date of Injury:</b>	04/18/2014
<b>Decision Date:</b>	04/06/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 44-year-old male who reported an injury on 04/18/2014. The injured worker was reportedly lifting a front loader washing machine when he strained his lower back. The current diagnoses include cervical herniated disc, mechanical low back pain, left sided radicular pain, left knee injury, cardiac murmur, and smoking. The injured worker presented on 08/04/2014 for a follow-up evaluation with complaints of neck pain radiating into the left arm and low back pain radiating into the left lower extremity. The current medication regimen includes Norco and an unknown muscle relaxant. Upon examination of the lumbar spine, there was a loss of lumbar lordosis, mild restriction, muscle spasm, and tenderness. There was good range of motion of the bilateral shoulders, patchy sensory changes in the C6-7 distribution, and diminished reflexes. There was patchy sensory loss in the lower extremities with diminished reflexes and equivocal straight leg raise. Recommendations at that time included precision guided injections at the C5-6 and C6-7 levels. An MRI of the lumbar spine and left knee was also recommended. There was no Request for Authorization form submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Selective nerve root block bilateral L5-S1:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines recommend epidural steroid injection as a treatment option for radiculopathy. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, it was noted that the injured worker reported persistent low back pain with left lower extremity symptoms. However, there was no objective evidence of radiculopathy upon examination. There was no mention of an attempt at any recent conservative treatment prior to the request for an injection. There were no imaging studies or electrodiagnostic reports submitted for review to corroborate a diagnosis of radiculopathy. Given the above, the request is not medically appropriate.

**Selective nerve root block left S1-S2:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines recommend epidural steroid injection as a treatment option for radiculopathy. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, it was noted that the injured worker reported persistent low back pain with left lower extremity symptoms. However, there was no objective evidence of radiculopathy upon examination. There was no mention of an attempt at any recent conservative treatment prior to the request for an injection. There were no imaging studies or electrodiagnostic reports submitted for review to corroborate a diagnosis of radiculopathy. Given the above, the request is not medically appropriate.

**Left sacroiliac trigger joint injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injection Page(s): 122.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

**Decision rationale:** The California MTUS Guidelines recommend trigger point injections only for myofascial pain syndrome. In this case, there was no documentation of circumscribed trigger points with evidence upon palpation of a twitch response and referred pain. There was no mention of a failure of medical management therapies such as exercise, physical therapy, and NSAIDs. Additionally, trigger point injections are not recommended when there is evidence of radiculopathy. Given the above, the request is not medically appropriate at this time.

