

<b>Case Number:</b>	CM15-0003455		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	06/19/2010
<b>Decision Date:</b>	03/13/2015	<b>UR Denial Date:</b>	12/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2015

### 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  
 Certification(s)/Specialty: Emergency Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 57 year old female with an industrial injury dated 11/29/2009. The mechanism of injury is not documented. Follow up visit dated 11/19/2014 noted the injured worker was complaining of severe neck pain with upper extremity symptoms. Other complaints were low back pain with lower extremity symptoms with bilateral wrist pain, numbness, tingling and weakness. Physical exam revealed decreased sensation in lumbar 5 and sacral 1 distribution bilaterally with a negative straight leg raise. Prior treatment includes epidural steroid injections to the cervical and lumbar spine. The provider states the injured worker "has benefited greatly" with lumbar epidural spine injections. On 10/22/201, the injured worker had been seen by an orthopedist and was diagnosed with bilateral carpal tunnel syndrome "per Agreed Medical Evaluation elect diagnostic findings". Diagnostic impression was: Chronic cervical pain with radiculopathy, Chronic lumbar pain with radiculopathy, Bilateral shoulder tendinosis, Bilateral wrist tendinosis, Elevated liver enzymes. On 12/19/2014 Utilization Review non-certified the request for epidural steroid injection lumbar 5 - sacral 1 noting there is limited evidence of objective documented pain and functional improvement with extent and duration of relief. MTUS Guidelines were cited. The request for referral to orthopedist was partially certified to referral to primary treating physician noting the guidelines do not address the level of specificity to justify the requested specific provider. Official Disability Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Epidural Steroid Injection L5-S1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Medical Treatment Guidelines, Epidural steroid injections (ESIs), page 46.

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

**Decision rationale:** The requested Epidural Steroid Injection L5-S1 is not medically necessary. Chronic Pain Medical Treatment Guidelines, p. 46, Epidural steroid injections (ESIs) note the criteria for epidural injections are "1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)." The injured worker has severe neck pain with upper extremity symptoms. Other complaints were low back pain with lower extremity symptoms with bilateral wrist pain, numbness, tingling and weakness. The treating physician has documented decreased sensation in lumbar 5 and sacral 1 distribution bilaterally with a negative straight leg raise. The treating physician has not documented physical exam evidence indicative of radiculopathy such as deficits in dermatomal sensation, reflexes or muscle strength; nor the percentage and duration of relief from a previous epidural injection. The criteria noted above not having been met, Epidural Steroid Injection L5-S1 is not medically necessary.

**Referral to Dr. [REDACTED]:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Assessing red flags for referrals, Chronic Pain Treatment Guidelines Chronic Pain, page 1, Part 1: Introduction Page(s): Page 1.

**Decision rationale:** The requested Referral to Dr. [REDACTED] is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, Low Back Complaints, Assessing red flags and indications for immediate referral, recommend specialist consultation with "physical exam evidence of severe neurologic compromised that correlates with the medical history and test results"; and California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 1, Part 1: Introduction, states "If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary." The injured worker has severe neck pain with upper extremity symptoms. Other complaints were low back pain with lower extremity symptoms with bilateral wrist pain, numbness, tingling and weakness. The treating physician has documented decreased sensation in lumbar 5 and sacral 1 distribution bilaterally with a negative straight leg raise. The treating physician has not documented medical necessity for an orthopedic

referral versus a primary care provider follow-up. The criteria noted above not having been met, Referral to Dr. [REDACTED] is not medically necessary.