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| <b>Case Number:</b>   | CM15-0007521 |                              |            |
| <b>Date Assigned:</b> | 01/23/2015   | <b>Date of Injury:</b>       | 04/11/2011 |
| <b>Decision Date:</b> | 03/23/2015   | <b>UR Denial Date:</b>       | 12/18/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/13/2015 |

### 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 39-year-old female who reported an injury on 04/11/2011 after lifting a box. The injured worker reportedly sustained an injury to her low back. The injured worker's treatment history included an L4-5 laminectomy, an L5-S1 laminectomy, and an L4-5 posterior fusion. Conservative treatments have included epidural steroid injections, physical therapy, the use of a TENS unit, multiple medications, and acupuncture. The injured worker was evaluated on 11/27/2014. It was documented that the injured worker had 6/10 to 9/10 pain that was exacerbated with activity. Physical findings included: a positive left sided straight leg raising test; 4+/5 left quadriceps, left tibialis anterior, left extensor hallucis longus, and left plantar flexor motor strength. The injured worker had decreased reflexes of the left ankle. The injured worker's diagnoses included postlaminectomy syndrome of the lumbar region, lumbar radiculopathy, and degenerative disc disease of the lumbar spine. The injured worker's treatment plan included a home exercise program, continuation of medications, and a caudal epidural steroid injection. A Request for Authorization was submitted on 12/01/2014 to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Caudal epidural steroid injection with anesthesia and fluoroscopy guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections..

**Decision rationale:** The requested caudal epidural steroid injection with anesthesia and fluoroscopy guidance is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends repeat epidural steroid injections be based on at least 50% pain relief for approximately 6 to 8 weeks and documentation of an increase in function. The clinical documentation submitted for review does indicate that the injured worker has previously undergone epidural steroid injections. Although radiculopathy is noted on physical examination, the effectiveness of previous injections was not discussed within the documentation. Therefore, an additional epidural steroid injection would not be supported. Furthermore, the request includes anesthesia. There is no documentation that the injured worker has any type of significant anxiety towards the procedure or needles. Therefore, anesthesia would not be supported. As such, the requested caudal epidural steroid injection with anesthesia with fluoroscopy guidance is not medically necessary or appropriate.