

<b>Case Number:</b>	CM15-0136054		
<b>Date Assigned:</b>	07/24/2015	<b>Date of Injury:</b>	02/23/2002
<b>Decision Date:</b>	08/20/2015	<b>UR Denial Date:</b>	06/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2015

### 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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The injured worker is a 69 year old female, who sustained an industrial injury on 2/23/02. Initial complaints were not reviewed. The injured worker was diagnosed as having cervical radiculopathy; thoracic sprain/strain; status post fusion L3-L5; instability L1-L2 and L2-L3 status post anteroposterior fusion T10-L5; brachial neuritis or radiculitis NOS. Treatment to date has included status post anterior/posterior lumbar fusion L1-S1 (1/13/10); status post anterior posterior fusion T10-L5; physical therapy; selective nerve block; steroid injections; back brace; urine drug screening; medications. Diagnostics studies included MRI lumbar spine (7/28/09); CT scan lumbar spine (7/19/09); X-rays lumbar spine (6/18/12); X-rays lumbar spine (5/6/15). Currently, the PR-2 notes dated 5/6/15 indicated the injured worker present in the office on this date for a follow-up of her mid-thoracic pain. She has some increased pain with gardening and reports she has no leg pain or numbness. Medications are listed as Norco 5/325mg two at bedtime with Tylenol and hydrochlorothiazide 25mg once daily. On physical examination, the provider notes some pain on palpation of the lower thoracic and upper lumbar spine. He also documents distally neurovascularly she is intact. X-rays of the lumbar spine on 5/6/15 notes an impression of stable posterior fusion T10-L5 without significant changes and narrowed L5-S1 disc space with mild degenerative changes mid-thoracic spine. She is a status post L3-L5 fusion with progressive adjacent disc disease and significant instability at L1-L2 and L2-L3 status post anterior/posterior fusion T10-L5. She reports some increased pain in the upper lumbar and lower thoracic spine. He documents if the symptoms continue, he will request a CT scan. The provider is requesting authorization of caudal lumbar epidural steroid injection to lumbar spine.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Caudal Lumbar Epidural Steroid Injection to lumbar spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 47 of 127.

**Decision rationale:** This claimant was injured in 2002 with cervical radiculopathy; thoracic sprain/strain; status post fusion L3-L5; instability L1-L2 and L2-L3 status post anteroposterior fusion T10-L5; brachial neuritis or radiculitis. There was past selective nerve block and steroid injections, with unknown objective functional improvement documented. As of May, the injured worker had continued thoracic pain. There is no leg pain or numbness. No dermatomal neurologic signs corresponding to an MRI disc herniation are noted. The MTUS recommends this as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). In this case, the MTUS criterion, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing," is not met. Further, the criterion for repeat ESI is at least 6-8 weeks of pain and improvement in function for 6-8 weeks following injection, and the outcomes from previous ESI are unknown, so this criterion cannot be assessed. The request is not medically necessary based on the above.