

<b>Case Number:</b>	CM15-0181191		
<b>Date Assigned:</b>	09/22/2015	<b>Date of Injury:</b>	04/25/2006
<b>Decision Date:</b>	10/27/2015	<b>UR Denial Date:</b>	08/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/15/2015

### 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: Connecticut, California, Virginia  
 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:

This is a 74 year old female with a date of injury on 4-25-06. A review of medical records indicates that the injured worker is undergoing treatment for neck, back, right shoulder and upper extremities. Treatments include: medication, physical therapy, chiropractic care, lumbosacral epidural injection, nerve ablation surgery on the cervical spine, right shoulder surgery, back surgery and right knee surgery. EMG and nerve conduction studies were done on 3-29-11, EMG was normal and NCS revealed mild ulnar motor neuropathy of the elbow and peripheral neuropathy. At the time of the exam she presented with complaints of lower back pain, neck pain, right lower extremity numbness radiating to the knee down to the foot, bilateral hand numbness and right medial thigh cramping. MRI of lumbar spine dated 3-25-11 multilevel loss of intervertebral disc height seen at L2 through the S1 levels and disc bulges are present and mild bilateral facet arthropathy changes seen. Primary treating physician's progress report dated 7-16-15 reports continued complaints of pain in the shoulders, neck, right knee and back pain. The main complaint is the low back pain that radiates into the legs, the right more than the left. She states she had an epidural steroid injection two years ago that gave her relief. Objective findings: lower back range of motion is limited in all directions. X-rays, three views done at this visit reveal significant abnormality of the lumbar spine with bone on bone at the upper lumbar levels by MRI scan at the L2-L3 and L3-L4 levels. Plan of care: refer for pain management consultation and lumbar steroid epidural injection. Request for authorization dated 8-4-15 for epidural steroid injection L3-4. The original utilization review denial of request dated 8-14-15.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Epidural steroid injection at L3-L4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** Per the MTUS Chronic Pain Guidelines (page 46), in order to warrant injections, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The MTUS criteria for epidural steroid injections also include unresponsiveness to conservative treatment (exercises, physical methods, and medications). The MTUS clearly states that the purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Given the recommendations for epidural steroid injections as written in the MTUS guidelines, without evidence of the prior injection described and albeit older (2011) nerve studies with no evidence of radiculopathy, the request for epidural steroid injection is not medically necessary.