MAXIMUS Federal Services

| Case Number: | CM15-0182687 | | |
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| Date Assigned: | 09/25/2015 | Date of Injury: | 07/14/2009 |
| Decision Date: | 10/30/2015 | UR Denial Date: | 09/10/2015 |
| Priority: | Standard | Application Received: | 09/16/2015 |

## 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: Arizona, California
Certification(s)/Specialty: Family Practice

## 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 50-year-old female, who sustained an industrial-work injury on 7-14-09. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar strain and sprain with discogenic pain and radiculopathy. Medical records dated (3-4-15 to 7-29-15) indicate that the injured worker complains of continued low back pain that has been progressively worsening. The pain is associated with stiffness, heaviness, weakness, radiating to the left lower extremity (LLE) with numbness, tingling and muscle spasm associated with repetitive movement. The pain is rated 6-8.5 out of 10 on the pain scale. The physician indicates that the injured worker has not returned to work. The medical records also indicate worsening of the activities of daily living due to pain. The physical exam dated (6-10-15 to 7-29-15) reveals that the lumbar spine has tenderness to palpation of the bilateral sacroiliac joints and lumbar muscles. There is decreased lumbar range of motion noted. There is spasm of the bilateral gluteus and lumbar muscles and sitting straight leg raise causes pain on the left. Treatment to date has included pain medication Voltaren, Cyclobenzaprine and Protonix, diagnostics, pain management, home exercise program (HEP), and other modalities. The treating physician indicates in the medical record dated 7-28-15 that the Magnetic resonance imaging (MRI) of the lumbar spine showed disc herniations. EMG-NCV (electromyography and nerve conduction velocity) testing was performed on 2-11-11 reveals lumbar radiculopathy. The request for authorization date was 8-25-15 and requested services included Lumbar epidural steroid injection at right L4-L5 and L5-S1 and RTC 8 weeks. The original Utilization review dated 9-10-15 non-certified as per the guidelines there is no documented clinical objective radiculopathy as

there is no reflex sensory or motor deficit. The lumbar Magnetic Resonance Imaging (MRI) and electrodiagnostic studies were not submitted to confirm radiculopathy and therefore, the request is not medically necessary. The request for RTC 8 weeks was non-certified as a follow up visit is not applicable since the epidural steroid injection (ESI) was non-certified.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar epidural steroid injection at right L4-L5 and L5-S1:** 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:** In this case, there is no correlation between EMG and physical findings. The physical findings do not indicate radicular symptoms in the L4-S1 distribution. The EMG only shows L4-L5 nerve root irritation. The guidelines recommend correlation between diagnostics and exam to justify an ESI. The request for the ESI is not medically necessary.

**RTC 8 weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7-page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter - office visits and pg 92.

**Decision rationale:** In this case, the claimant does not require an ESI as noted above. The guidelines require correlation between diagnostics and exam for radiculopathy. Since the ESI is not appropriate, the request to return to clinic to follow up for procedure is not required. Therefore the request is not medically necessary.