

<b>Case Number:</b>	CM15-0186873		
<b>Date Assigned:</b>	09/28/2015	<b>Date of Injury:</b>	07/26/2012
<b>Decision Date:</b>	11/03/2015	<b>UR Denial Date:</b>	09/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2015

### 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: Massachusetts

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 44 year old female who sustained an industrial injury 07-26-12. A review of the medical records reveals the injured worker is undergoing treatment for thoracic or lumbosacral neuritis or radiculitis, and lumbar or lumbosacral disc degeneration, depressive disorder, generalized anxiety disorder, and pain disorder. Medical records (09-01-15) reveal the injured worker complains of lower back and right hip pain, rated at 10/10 without medications and 5/10 with medications. This is compared to 08-10-15 when her pain was rated at 8/10 with no mention of medications and 07-14-15 when her pain was rated at 9/10 again without mention of medications. The physical exam (09-01-15) reveals restricted range of motion of the lumbar spine, limited by pain. Lumbar facet loading is positive on the right side. Prior treatment includes acupuncture, oral and topical medications. The original utilization review (09-15-15) non-certified the request for a right L4-5 lumbar epidural steroid injection.

### 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 level:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** The claimant sustained a work injury in July 2012 and is being treated for low back and right lower extremity pain. An MRI of the lumbar spine is referenced as showing a right lateralized disc herniation at L4/5 and a broad-based herniation at L5/S1. When seen, she was having low back pain with radiating pain into the right lower extremity to her foot. Physical examination findings included decreased right lower extremity sensation. There was decreased and painful lumbar spine range of motion with positive facet loading. Authorization was requested for a lumbar epidural injection. Criteria for the use of epidural steroid injections include radicular pain, defined as pain in dermatomal distribution with findings of radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, the claimant's provider documents decreased lower extremity sensation and imaging is reported as showing findings consistent with the right sided physical examination findings and the claimant's radicular pain complaints. The requested epidural steroid injection is medically necessary.