Case Number:	CM15-0196252		
Date Assigned:	10/09/2015	**Date of Injury:**	11/01/2010
Decision Date:	11/18/2015	**UR Denial Date:**	09/29/2015
Priority:	Standard	**Application Received:**	10/06/2015

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, Oregon, Washington
Certification(s)/Specialty: Orthopedic Surgery

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 54 year old male, who sustained an industrial injury on 11-1-2010. The injured worker was being treated for lumbar spine radiculopathy with pain. Medical records (6-24-2015 to 9-22-2015) indicate ongoing lumbar spine pain radiating down the left leg to the toes. Associated symptoms include numbness and tingling down the left leg. The medical records show the subjective pain rating shows no significant improvement from 4-7 out of 10 on 6-24-15 to 4-8 out of 10 on 9-22-2015. The physical exam (9-22-2015) revealed healed lumbar surgical scar and bilateral posterior superior iliac spine pain. Surgeries to date have included a hemilaminectomy, medial facetectomy and foraminotomy, and facet rhizotomy at left L5-S1 (lumbar 5-sacral 1) on 12-03-2014. On 4-24-215, the injured worker underwent a transforaminal epidural steroid injection and left L5. Per the treating physician (4-29-2015 report), the injured worker reported he did not see any difference after the epidural steroid injection administered on 4-24-2015. Treatment has included unspecified type of therapy, work restrictions, and medications pain, anti-epilepsy, and proton pump inhibitor. Per the treating physician (9-22-2015 report), the injured worker may return to modified work with restrictions that include no lifting, pushing, or pulling over 10-15 pounds and no repetitive bending, stooping, squatting, or twisting. The requested treatments included an epidural steroid injection at L4-5 (lumbar 4-5). On 9-29- 2015, the original utilization review non-certified a request for an epidural steroid injection at L4-5.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural steroid injection at L4-5: Upheld

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

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

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, Epidural injections, page 46, "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." Specifically the guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. In addition, there must be demonstration of unresponsiveness to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, the exam notes cited do not demonstrate a failure of conservative management or a clear evidence of a dermatomal distribution of radiculopathy. Therefore, the request is not medically necessary.