

<b>Case Number:</b>	CM15-0025678		
<b>Date Assigned:</b>	02/18/2015	<b>Date of Injury:</b>	02/13/2010
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	01/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2015

### 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  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 31-year-old female, who sustained an industrial injury on 2/13/10. The injured worker has complaints of low back pain and right le radicular pain with numbness symptoms. The diagnoses have included lumbar herniated nucleus pulposus/degenerative disc disease with radiculopathy; status post tranforaminal lumbar interbody fusion September 16, 2012 and new adjacent l3-L4 herniated nucleus pulposus. The documentation noted that the injured worker has had epidural steroid injection, which helped moderately. According to the utilization review performed on 1/9/15, the requested Right L3-4 epidural Steroid Injection has been non-certified. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic Pain, page 46 was used in the utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right L3-4 epidural Steroid Injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47.

**Decision rationale:** The patient presents with low back pain radiating to Right leg. The request is for RIGHT L3-4 EPIDURAL STEROID INJECTION. The request for authorization is dated 01/06/14, however, it was handwritten and appears the treater made a mistake and should be 01/06/15. The patient is status-post transforaminal lumbar interbody fusion 09/18/12. X-ray of the lumbar spine 07/28/14 shows alignment and height of the vertebral bodies are not significant changed, with no spondylolisthesis noted, multilevel intervertebral disc space narrowing is again identified, with no significant wall change in intervertebral disc space of L3-L4. She had an epidural steroid injection which helped her moderately. Patient's medications include Hydrocodone, Tramadol and Tizanidine. The patient is temporarily totally disabled. MTUS page 46,47 states that an ESI is Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). MTUS further states: Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year." Treater has not provided reason for the request. Per progress report dated 10/27/14, treater states patient had an epidural injection "which helped her moderately." For a repeat injection, MTUS requires objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, which the treater has failed to provide. Furthermore, the provided imaging report does not corroborate radiculopathy. Therefore, this request IS NOT medically necessary.