

<b>Case Number:</b>	CM15-0222697		
<b>Date Assigned:</b>	11/18/2015	<b>Date of Injury:</b>	05/31/2015
<b>Decision Date:</b>	12/30/2015	<b>UR Denial Date:</b>	10/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2015

### 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, Indiana, New York  
Certification(s)/Specialty: Internal 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:

The injured worker is a 56-year-old female who sustained an industrial injury on 5-31-2015. A review of medical records indicates the injured worker is being treated for fracture of pubis-closed. Medical records dated 9-4-2015 noted pain was 10 out of 10 with activities of daily living and ambulation. She reported moderated difficulty with activities of daily living at home and is unable to ambulate greater than 30 minutes using axillary crutches. Physical examination noted increased range of motion since the last visit dated 7-2-2015. Treatment has included 8 sessions of aquatic therapy. She has demonstrated significant improvement with aquatic therapy in AROM and strength. She revealed moderate limitations in range of motion and strength. Utilization review form dated 10-30-2015 noncertified lumbar epidural steroid injection at the level of L5-S1 with a catheter to be threaded superiorly to the level of L2 through L5 under fluoroscopic guidance.

### 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 the level of L5-S1 with a catheter to be threaded superiorly to the level of L2 through L5 under fluoroscopic guidance: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Epidural steroid injections (ESIs).

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, lumbar epidural steroid injection at level L5-S1 with a catheter to be threaded superiorly to the level of L2-L5 under fluoroscopy is not medically necessary. Epidural steroid injections are recommended as an option for treatment of radicular pain. The criteria are enumerated in the Official Disability Guidelines. The criteria include, but are not limited to, radiculopathy must be documented by physical examination and corroborated by imaging studies and or electrodiagnostic testing; initially unresponsive to conservative treatment (exercises, physical methods, non-steroidal anti-inflammatories and muscle relaxants); 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 6 to 8 weeks, etc. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications and functional response, etc. See the guidelines for details. In this case, the injured worker's working diagnoses are contusion right hip; and pelvic fracture closed right. Date of injury is May 31, 2015. Request for authorization is October 23, 2015. The requesting provider is a pain management physician. There is a single procedure note in the medical record dated October 14, 2015 by the requesting provider for a right sacroiliac joint injection under fluoroscopy. There was no contemporaneous clinical documentation from the requesting provider with a clinical discussion, indication or rationale for a lumbar epidural steroid injection at level L5-S1 with a catheter to be threaded superiorly to the level of L2-L5 under fluoroscopy. According to an Occupational Medicine progress note dated September 21, 2015, the worker sustained fractured pubis and has ongoing right hip pain. Objectively, there is no tenderness in the lumbar spine and no decreased range of motion of the lumbar spine. Neurologically there was no muscle weakness in the legs. There was no objective evidence of radiculopathy. According to the utilization review, the reviewer referenced an October 21, 2015 progress note. This progress note was not present in the medical record under review. The injured worker followed up after the SI joint injection with increased in range of motion, decreased in medication use and decrease in numbness and tingling sensation. Physical examination (according to this progress note) states moderate tenderness of the bilateral paraspinal muscle groups with moderate guarding on deep palpation. Range of motion is decreased. Straight leg raising is positive on the right. The injured worker ambulates normally. Motor strength is 5/5 and the lower extremities and 4/5 in the bilateral ankle dorsiflexors. Sensation is intact. Utilization review indicates physical examination shows the patient has some weakness in the L5 distribution bilaterally. Imaging does not show nerve root impingement at any level that would warrant an epidural steroid injection. It is unclear why the epidural steroid injection would be performed as a caudal epidural with a catheter threaded to the L2 level based on no objective clinical findings, upper lumbar radiculopathy or any findings on MRI showing nerve impingement. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, no contemporaneous clinical documentation on or about the date of request for authorization referencing the lumbar epidural steroid injection with a clinical discussion, indication and rationale for the epidural steroid injection, lumbar epidural steroid injection at level L5-S1 with a catheter to be threaded superiorly to the level of L2-L5 under fluoroscopy is not medically necessary.