

<b>Case Number:</b>	CM15-0058964		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	06/23/2012
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	03/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2015

### 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: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational 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 60 year old male, who sustained an industrial injury on 6/23/2012. He reported injury from a fall from a platform. The injured worker was diagnosed as having cervical sprain/strain, right shoulder strain-status post-surgery, lumbar radiculopathy, bilateral knee strain and intermittent left chest pain. There is no record of a recent diagnostic study. Treatment to date has included surgery and medication management. In a progress note dated 2/25/2015, the injured worker complains of low back pain that radiates to the left knee. The treating physician is requesting a lumbar epidural steroid injection and Naproxen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar epidural steroid injection with fluoroscopic guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI criteria for epidural steroid injections Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** The injured worker sustained a work related injury on 6/23/2012. The medical records provided indicate the diagnosis of cervical sprain/strain, right shoulder strain-status post-surgery, lumbar radiculopathy, bilateral knee strain and intermittent left chest pain. There is no record of a recent diagnostic study. Treatment to date has included surgery and medication management. The medical records provided for review do not indicate a medical necessity for Lumbar epidural steroid injection with fluoroscopic guidance. The EMG of 01/29/2013 was positive for Left L5 Radiculopathy, while the lumbar MRI of 03/14/ 2013 negative for radiculopathy. The medical records indicate the injured worker has low back pain that radiates to the legs, the physical examination was positive for straight leg raise (radiculopathy feature), Lumbar MRI of 2013 was positive for degenerative disc diseases , but negative for radiculopathy; EMG of 2013 was positive for Left L5 Radiculopathy. The MTUS Criteria for Epidural steroid injection are as follows: Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) 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. The request does not specify the location for the injection. The request is not medically necessary.

**Naproxen 550 #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-68, 73.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain discussion; NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 8; 67-73.

**Decision rationale:** The injured worker sustained a work related injury on 6/23/2012. The medical records provided indicate the diagnosis of cervical sprain/strain, right shoulder strain-status post-surgery, lumbar radiculopathy, bilateral knee strain and intermittent left chest pain. There is no record of a recent diagnostic study. Treatment to date has included surgery and medication management. The medical records provided for review do not indicate a medical necessity for Naproxen 550 #60. Naproxen is an NSAID. The MTUS recommends the use of the lowest dose of NSAIDs for the shortest period in patients with moderate to severe pain. The medical records indicate the injured worker has been using this medication since 10/2012, but without overall improvement. The MTUS recommends periodic review of treatment modality, if the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities. The request is not medically necessary.

