

<b>Case Number:</b>	CM14-0121910		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	09/26/2002
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	07/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Louisiana. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 59 year old female who was injured on 09/26/2002. The mechanism of injury is unknown. Prior medication history included Lidoderm 5% patches. Diagnostic studies reviewed include MRI of the lumbar spine dated 11/28/2011 revealed postoperative changes and lower lumbar spondylosis. There are no updated studies available for review. Follow-up note dated 06/30/2014 states the patient presented with complaints of severe pain and numbness with radiation down the legs, right worse than left. She rated her pain as a 6/10. Objective findings on exam revealed sitting straight leg raise causes pain. There is restricted range of motion of the lumbar spine. Axial back pain is present with radiation to the knee and medial malleolus on the right consistent with L3 radiculopathy. The patient is diagnosed with lumbar spondylolisthesis L3-4 and L4-5; severe lumbar spine stenosis at L3-4 and L4-5; lumbar radiculopathy on the right, low back pain, and status post prior spinal fusion surgery on the left L5-S1. The patient has been recommended for a lumbar epidural injection. Prior utilization review dated 07/09/2014 states the request for Lumbar epidural steroid injection is not certified as there is no documented benefit from this receiving this treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar epidural steroid injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary

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

**Decision rationale:** Based on the Chronic Pain Medical Treatment Guidelines, Epidural Steroid Injection is recommended as an option for treatment of radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. Repeat blocks should be based on continued objective documented pain and functional improvement. In this case, there is consistent L3 radiculopathy; however, there is no documentation of duration of pain relief or objective functional gains obtained from prior epidural steroid injection to support the necessity of this request. Therefore, the request for Lumbar Epidural Steroid Injection is not medically necessary and appropriate.