

<b>Case Number:</b>	CM14-0139947		
<b>Date Assigned:</b>	09/08/2014	<b>Date of Injury:</b>	09/11/2012
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	07/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2014

### 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 Nevada. 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 records presented for review indicate that this 48 year-old male was reportedly injured on 9/11/2012. The most recent progress note, dated 6/5/2014, indicates that there were ongoing complaints of low back pain that radiates in the left lower extremity the physical examination demonstrated acupuncture. No recent diagnostic studies are available for review. Lumbar spine: positive tenderness to palpation midline at the L5-S2, lumbosacral paraspinal region and PSI S/buttock tenderness. Tenderness of the left piriformis. Decreased muscle strength of the left lower extremity 4/5 at EHL and ankle dorsiflexion. Decreased sensation light touch of the left lower extremity along the L5 dermatome. Positive straight leg raise on the left. Favorite maneuver causes left medial groin pain. Decreased left hip internal/external rotation. Previous treatment includes epidural steroid injections, physical therapy, medications, and conservative treatment. A request had been made for transforaminal epidural steroid injection of the lumbar spine at S1 and was not certified in the pre-authorization process on 7/29/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**S1 TFESI with a left S1 joint injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Epidural steroid inject.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46 of 127..

**Decision rationale:** The MTUS guidelines support epidural steroid injections when radiculopathy is documented on physical examination and corroborated by imaging and electrodiagnostic studies in individuals who have not improved with conservative care. Based on the clinical documentation provided, and considering the criteria for the use of epidural steroid injections as outlined in the MTUS; there is insufficient clinical evidence presented that the proposed procedure meets the MTUS guidelines. Specifically, there is no documentation of what percentage of pain relief the patient have from previous injections as well as duration of affect. As such, the requested procedure is deemed not medically necessary.