

<b>Case Number:</b>	CM14-0162607		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	04/17/2013
<b>Decision Date:</b>	10/30/2014	<b>UR Denial Date:</b>	09/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2014

### 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 Twxas. 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:

Medical records reflect the claimant is a 45 year old male who sustained a work injury on 4-17-13. Office visit on 7-24-14 notes the claimant has longstanding pain. The claimant has been treated with chiropractic therapy and cervical epidural steroid injection with a few days relief. The claimant reports neck pain that radiates to triceps, FA, and hand bilaterally. He has low back pain with radiation posteriorly into HS and stopping at the calf. On exam, the claimant had limited range of motion of the lumbar spine in flexion and extension. The claimant had weakness at right 4/5 posterior tibialis, EHL, and peroneal, weakness at left tib anterior, posterior tib and EHL. The claimant had difficulty with toe and heel walking.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) lumbar epidural steroid injection at L5-S1 (unspecified laterality): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): Table 2- Summary of Recommendations.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injection Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar epidural steroid injection

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG notes that epidural steroid injection is recommended but radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Medical Records reflect this claimant had weakness at right 4/5 posterior tibialis, EHL, and peroneal, weakness at left tib anterior, posterior tib and EHL. Therefore, the request is not medically necessary.