Case Number:	CM15-0100273		
Date Assigned:	06/02/2015	**Date of Injury:**	04/21/2011
Decision Date:	06/30/2015	**UR Denial Date:**	05/14/2015
Priority:	Standard	**Application Received:**	05/26/2015

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: New York, Pennsylvania, Washington
Certification(s)/Specialty: Internal Medicine, Geriatric 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 58 year old male, who sustained an industrial injury on 4/21/11. He reported initial complaints of low back, left knee and right shoulder injury. The injured worker was diagnosed as having low back strain with multilevel degenerative facet joint arthropathy, mild at the L1-2 , moderate bilaterally at L2-S1 levels/ severe disc space narrowing and severe left and moderate to severe right foraminal stenosis L5-S1.; status post left knee arthroscopy with partial medial and lateral meniscectomies/ removal of medial compartment loose body/limited synovectomy (11/5/13); medial compartment degenerative joint disease left knee; right shoulder impingement syndrome, Type III acromion/degenerative joint disease acromioclavicular joint/high grade partial thickness bursal side rotator cuff tear with small full thickness tear anterior distal supraspinatus tendon right shoulder with severe rotator cuff tendinopathy; myocardial infarction (12/21/11). Treatment to date has included back brace; epidural steroid injection lumbar; status post left knee arthroscopy with partial medial meniscectomy and debridement (11/5/13); physical therapy; medications. Diagnostics included MRI lumbar spine (3/7/14). Currently, the PR-2 notes dated 5/16/14 documented as an agreed medical re- examination. These notes indicated the injured worker complains of right shoulder and left knee pain as a result of an industrial injury. A detailed history is noted from the date of injury and including a cardiovascular history of myocardial infarction (12/31/2011) with prior heart attack. The provider also notes a history of thyroid problems and use of cortisone. The MRI of the lumbar spine dated 3/7/14 reveals multilevel foraminal stenosis moderate at L3-S1 levels bilaterally. He has had an epidural steroid injection to the lumbar spine 4/11/14 after his injury and is a status post left knee arthroscopy with partial medial meniscectomy and debridement (11/5/13). His back pain currently is rated as 1-2/10 but has serious sciatic symptoms and that can elevate to 9/10. He states the severe pain will cause numbness and

aching in his groin and mid-section. The pain is noted in the tailbone, lower back and groin area and radiates to the front and back of his legs when severe. His left knee pain is rated as 1/10 but has aching in the left knee. He was off work for about 6 weeks after knee surgery but back to work working full duty without restrictions. The provider documents a physical examination. With regard to the lumbar spine, the provider documents it was felt the injured worker would benefit from analgesics, injection and lumbosacral brace with rigid stays. Surgery would include a lumbar decompression instrumented fusion of the L5-S1 level with bone grafting. For the right shoulder, analgesics, injections with corticosteroid local anesthesia. Mumford procedure if cleared by his cardiologist and diagnostic studies. For the left knee, the provider suggested analgesics, corticosteroid local anesthetic injections, MRI. The provider is requesting an Epidural Steroid injection at L4-5 times one.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural steroid injection L4-5, quantity: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 35.

Decision rationale: Per the guidelines, epidural spine injections are recommended as an option for treatment of radicular pain. Most current guidelines recommend no more than 2 injections. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. Though the physical exam does suggest radicular pathology, the worker does not meet the criteria as there is not clear evidence in the records that the worker has failed conservative treatment with exercises, physical methods, NSAIDS and muscle relaxants. The epidural injection is not medically necessary.