

<b>Case Number:</b>	CM15-0122679		
<b>Date Assigned:</b>	07/13/2015	<b>Date of Injury:</b>	05/10/2011
<b>Decision Date:</b>	08/10/2015	<b>UR Denial Date:</b>	06/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 40-year-old female, who sustained an industrial injury on 05/10/2011. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having thoracic or lumbosacral spine neuritis or radiculitis not otherwise specified and skin sensation disturbance. Treatment and diagnostic studies to date has included medication regimen and a functional restoration program. In a progress note dated 05/29/2015 the treating physician reports complaints of moderate to severe, squeezing pain to the low back that radiates to the left thigh. Examination reveals decreased sensation to the lumbar five and sacral one dermatomes on the left side, decreased motor strength to the left knee, decreased range of motion to the lumbar spine, tenderness to the left lumbar paravertebral muscles, tenderness to the lumbar three through five spinous processes, positive facet loading on the left, and tenderness to the sacroiliac spine. The treating physician requested a transforaminal epidural steroid injection to the left lumbar four, lumbar five, and sacral one with the treating physician noting subjective and objective findings of radiculopathy that are consistent with diagnostic studies and that this procedure will provide medication directly to the target site.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transforaminal Epidural Steroid Injection at the Left Sided L4, L5, and S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

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

**Decision rationale:** Transforaminal Epidural Steroid Injection at the Left Sided L4, L5, and S1 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that 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. In a progress note dated 1/26/15, the documentation indicates that the patient has had a L5-S1 transforaminal epidural steroid injection. The documentation does not indicate that this injection resulted in reduction of medication use for six to eight weeks therefore the request for another transforaminal epidural steroid injection is not medically necessary.