

<b>Case Number:</b>	CM15-0125234		
<b>Date Assigned:</b>	07/09/2015	<b>Date of Injury:</b>	08/26/2009
<b>Decision Date:</b>	08/06/2015	<b>UR Denial Date:</b>	06/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/29/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 53 year old female who sustained an industrial /work injury on 8/26/09. She reported an initial complaint of low back pain and left hip pain. The injured worker was diagnosed as having displacement of lumbar intervertebral disc without myelopathy, cervical disc degeneration, cervical facet syndrome, and cervical pain. Treatment to date includes medication, physical therapy, and epidural steroid injection at left L5 and left S1 levels. Currently, the injured worker complained of lower backache and increased low back left hip pain. Pain is rated 6/10 with medication. Per the primary physician's report (PR-2) on 6/4/15, exam noted antalgic gait with use of a cane, inability for heel walking and single leg standing with the left lower extremity, lumbar range of motion is restricted, motor strength is 5/5 on right and 4/5 on left. The requested treatments include Left transforaminal lumbar epidural injection at L5 and S1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left transforaminal lumbar epidural injection at L5 and S1:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 48-49.

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

**Decision rationale:** According to the MTUS, several diagnostic criteria must be present to recommend an epidural steroid injection. The most important criteria are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. MTUS recommends no more than 2 ESI injections. Patient had a transforaminal lumbar epidural injection previous on December 17, 2014 and reported a 50% increase functional improvement and pain relief which lasted for at least eight weeks. I am reversing the previous utilization review decision. Left transforaminal lumbar epidural injection at L5 and S1 is medically necessary.