

<b>Case Number:</b>	CM15-0179289		
<b>Date Assigned:</b>	09/21/2015	<b>Date of Injury:</b>	02/09/2013
<b>Decision Date:</b>	10/30/2015	<b>UR Denial Date:</b>	08/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2015

### 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, North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 (IW) is a 55 year old male who sustained an industrial injury on 02-09-2013. The worker has injuries to the neck, shoulder, back, hips, and lower extremities. His diagnoses include Cervical spine myofascial sprain-strain, Cervical spondylosis, Cervical radiculitis, Lumbar spine myofascial sprain-strain, Lumbar spondylosis, Left shoulder impingement syndrome, Early degenerative joint disease, right knee, Carpal Tunnel syndrome, left hand, and Right ankle sprain. Treatment to date has included chiropractic care, and physical therapy. On 06-18-2015, the worker had a radiofrequency, left cervical facet Neurotomy C5-6 and C6-7 medial branch Neurotomy after the worker had a bilateral C5-C6 and C6-C7 facet injection on 04-10-2015 with 75% -85% temporary pain relief and good functional improvement of pain. According to 01-27-2015 reports, a MRI (02-11-2013) showed L2 and L2 compression deformities with loss of 30% of anterior height, 4 mm left dorsolateral broad-based disc protrusion with a spur at L5-S1 with no thecal stenosis, with moderate left foraminal stenosis and facet hypertrophy with possible involvement of the left L5 existing roots. He is on pain medications of Flexeril, Norco, and Neurontin. In the provider notes of 07-28-2015 the injured worker complains of pain in the low back, bilateral buttock, and groin. Pain in low back occurs with activity and with sitting, standing, or walking greater than 20-30 minutes. On exam, the worker has pain in a L3-L5 with facet tenderness. Pain increases in the morning. Lumbar spine pain also increases with extension and side lying. Pain is described as sharp, shooting, stabbing and burning in nature at a level of 6 on a scale of 0-10 and associated with muscle spasms in the lumbar area. He has no leg pain. Deep tendon reflexes are normal bilaterally. The treatment plan was for continued treatment with the pain management specialist. A request for authorization was submitted for: Lumbar epidural steroid injection at left L5-S1 under fluoroscopy guidance. A utilization review decision 08-05-2015 non-certified the request.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar epidural steroid injection at left L5-S1 under fluoroscopy guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** CA MTUS Guidelines state that ESI are recommended as an option for treatment of radicular pain. There are specific criteria for ESI and "Radiculopathy must be documented by physical exam and corroborated by imaging studies and electrodiagnostic testing." In this case, there is a discrepancy between the provider verbal report to the previous reviewer and the documentation in the medical records. The medical records indicate no radiating leg pain and a normal neurologic exam. There are no nerve root compressive findings. The patient has no leg pain and his deep tendon reflexes are normal. MRI from 2012 shows moderate left foraminal stenosis in the lumbar spine. No electrodiagnostic studies are available for review. In this case, due to the lack of documentation of radicular symptoms, the request is not medically necessary or appropriate.