

<b>Case Number:</b>	CM17-0005418		
<b>Date Assigned:</b>	01/12/2017	<b>Date of Injury:</b>	10/22/2016
<b>Decision Date:</b>	02/06/2017	<b>UR Denial Date:</b>	01/06/2017
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2017

### 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 57 year old male, who sustained an industrial injury on 10-22-16. Medical records indicate that the injured worker is undergoing treatment for a lumbar sprain-strain, lumbar radiculopathy, lumbar radiculitis, sacroiliac segmental dysfunction, cervical sprain, cervical muscle pain, cervical segmental dysfunction and a right knee contusion. The injured worker is currently working full time. On (12-21-16) the injured worker complained of constant neck pain, low back pain and right leg pain. The pain was rated 6 out of 10 at its worst and 3-4 at its best on the visual analogue scale. The pain was described as pressure-like and shooting. Lumbar spine examination revealed a restricted range of motion. Tenderness to palpation was noted over the right lumbar paraspinal muscles with spasms. A lumbar facet loading maneuver was negative. A straight leg raise was positive on the right. Sensation was diminished in the lumbar four and lumbar five dermatomes of the lower extremities. Motor strength was normal in the bilateral lower extremities. The treating physician recommended lumbar epidural steroid injections to reduce pain and inflammation and to restore range of motion, thereby facilitating progress in more active treatment programs and avoiding surgery. Treatment and evaluation to date has included medications, urine drug screen, chiropractic treatments, physical therapy, a home exercise program and a myofascial release. Current medications include Tramadol ER, Ketoprofen, Metoprolol and Hydrochlorothiazide. No MRI report was available. The Request for Authorization dated 12-29-16 included requests for a right L5 transforaminal epidural steroid injection under fluoroscopic guidance and a right L4 transforaminal epidural steroid injection under fluoroscopic guidance. The Utilization Review

documentation dated 1-6-17 non-certified the requests for a right L5 transforaminal epidural steroid injection under fluoroscopic guidance and a right L4 transforaminal epidural steroid injection under fluoroscopic guidance.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Right L4 transforaminal epidural steroid injection under fluoroscopic guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations, Physical Methods, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Thoracic and Lumbar, Acute and Chronic) Chapter, Epidural Steroid Injection (ESI) and Other Medical Treatment Guidelines [www.mdguidelines.com](http://www.mdguidelines.com).

**Decision rationale:** Regarding the request for Right L4 transforaminal epidural steroid injection under fluoroscopic guidance, Non MTUS guidelines were also used since they have specific criteria for the request. ACOEM states that epidural injections (ESI) are recommended as an option for treatment of radicular pain. MTUS Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, to avoid surgery. ODG states radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Within the documentation available for review, there are no recent MRI or electrodiagnostic studies supporting a diagnosis of radiculopathy on the right L4, and no documentation of failed muscle relaxant treatment. In the absence of such documentation, the currently requested Right L4 transforaminal epidural steroid injection under fluoroscopic guidance, is not medically necessary.

**Right L5 transforaminal epidural steroid injection under fluoroscopic guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations, Physical Methods, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Thoracic and Lumbar, Acute and Chronic) Chapter, Epidural Steroid Injection (ESI) and Other Medical Treatment Guidelines [www.mdguidelines.com](http://www.mdguidelines.com).

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