

<b>Case Number:</b>	CM13-0033836		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	07/13/2012
<b>Decision Date:</b>	02/07/2014	<b>UR Denial Date:</b>	10/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 claimant is a 53-year-old female Clerk who was injured on July 13, 2012 lifting a bin of charts that caused her to have the sudden severe onset of low back pain with radiation to the left leg and foot. She was diagnosed with low back pain, herniated nucleus pulposus and stenosis. She has had no previous surgeries. Diagnostic studies include an MRI of her lumbar spine dated July 31, 2012 which showed moderate to severe degenerative joint disease at L5-S1 with moderate narrowing, and posterior marginal osteophytes with a 5 millimeter intervening disc protrusion. The protruding disc did not impinge on the nerve roots. A 3/11/13 Lumbar spine MRI: revealed a L5-S1: 4 to 5 mm circumferential disc bulge with mild bilateral neural foraminal narrowing. Per 10/3/12 documentation by [REDACTED]: She has severe back pain that has not improved with physical therapy, activity modification, time or pain medication. [REDACTED] wanted to proceed with consideration of epidural injections prior to proceeding with a lumbar fusion. [REDACTED]' exam on November 14, 2012 revealed lumbar and right paraspinal tenderness. Range of motion was 50 percent of normal. She had a negative straight leg raise and negative Spurling test. Muscle strength and lower extremity reflexes were normal and there were no sensory hyper- paresthesias. She had negative clonus and Homans signs. A subsequent office visit on December 19, 2012 revealed increased pain, severe back pain and continued numbness and tingling in the lower extremity, leg and foot on the left side. Neurovascular sensation was intact and there were no pathologic reflexes. Per 12/19/12 documentation by [REDACTED]: She has failed all conservative treatments and the epidural injection only helped her for approximately one to 2 days. She has severe back pain and leg pain. The leg pain is hard to explain secondary to the very small nature of the disc herniation in the mild foraminal stenosis. The back pain is likely secondar

## IMR ISSUES, DECISIONS AND RATIONALES

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

**2nd lumbar ESI L5-S1:** Upheld

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

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

**Decision rationale:** A 2nd lumbar ESI L5-S1 is not medically necessary per MTUS guidelines. Per guidelines, "If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. No more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level should be injected at one session. 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, with a general recommendation of no more than 4 blocks per region per year." The patient did not have an adequate response to her first epidural injection therefore a second lumbar epidural steroid injection is not medically necessary.