

<b>Case Number:</b>	CM14-0006134		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	07/30/2013
<b>Decision Date:</b>	06/27/2014	<b>UR Denial Date:</b>	12/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/16/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/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 underlying date of injury in this case is 12/27/2013. The patient's treating diagnoses include lumbar strain, lumbago, and sacroiliitis. An MRI of the lumbar spine on 10/07/2013 describes disc desiccation with osteophytes at L3-L4, osteophytes at L4 L5 with mild narrowing of the right neural foramen, and disc desiccation with a 1-mm bulge at L5-S1, without thecal sac or nerve root compression. On 12/06/2013, the patient was seen in an initial orthopedic consultation with complaints of constant, severe, aching, left-sided upper and midback pain and constant, sharp, and severe low back pain on the left side. The pain was in both legs and frequent, sharp, and severe. On physical examination, the patient had 4/5 strength in left lateral flexion of the spine. No clear focal lower extremity neurological deficits were noted. The patient was diagnosed with a 1-mm disc herniation and lumbar neuritis/radiculitis. The proposed treatment plan includes anti-inflammatory medications, physical therapy, and also a lumbar epidural injection at L4-S1 times two (2).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LUMBAR EPIDURAL STEROID FACET INJECTION OF THE RIGHT L4-L5, L5-S1:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG),

Treatment index, 11th Edition (web), Low Back Chapter, Facet joint diagnostic blocks (injections).

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

**Decision rationale:** The Chronic Pain Guidelines indicate that radiculopathy must be documented on physical examination and should be corroborated by diagnostic studies, such as imaging or electrodiagnostic studies. The medical records at this time do not match the presence of such a radiculopathy, and the medical records do not provide an alternate rationale for this request. Overall, this request is not medically necessary.