

Case Number:	CM13-0037761		
Date Assigned:	12/18/2013	Date of Injury:	05/29/2013
Decision Date:	03/21/2014	UR Denial Date:	09/10/2013
Priority:	Standard	Application Received:	10/01/2013

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 Orthopedic Surgery, has a Fellowship trained in Spine Surgery, 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 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 patient is a 45-year-old female who reported an injury on 05/29/2013 due to a slip and fall reportedly caused injury to her low back. An x-ray report dated 05/31/2013 documented that the patient had normal alignment and minimal anterolisthesis of the L5 on S1 with mild L5-S1 degenerative disc disease and L5-S1 facet degenerative changes. The patient was conservatively treated with medications and physical therapy. The patient's most recent clinical examination revealed that the patient had persistent moderate pain in the low back with physical findings to include "diffuse hesitancy on the left side" no focal sensory disturbances. The patient's treatment plan included a standing flexion and extension x-ray to evaluate the patient's L5-S1 and assess for instability, and L5-S1 transforaminal selective nerve root block to identify the patient's symptoms are radicular in nature, in consideration of surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for 1 left L5-S1 transforaminal selective nerve root block/epidural between 8/28/2013 and 11/9/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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

Decision rationale: The California Medical Treatment Utilization Schedule recommends epidural steroid injections for patients who have physical findings of radiculopathy that are corroborated by an imaging study and nonresponsive to conservative treatments. The clinical documentation submitted for review does not clearly identify radicular complaints that are supported by physical examination findings. Additionally, although it is noted within the documentation that the patient underwent an MRI (magnetic resonance imaging) this was not provided for review. For the need for a transforaminal selective nerve root block cannot be determined. As such, the prospective request for 1 left L5-S1 transforaminal selective nerve root block/epidural between 8/28/2013 and 11/9/2013 is not medically necessary or appropriate.

Prospective request for 1 x-ray of the lumbar spine, flexion/extension between 8/28/2013 and 11/9/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient previously underwent this type of imaging study. The American College of Occupational and Environmental Medicine do not recommend x-rays in the absence of red flag conditions or serious spinal pathology. The clinical documentation submitted for review does not provide any evidence that the patient has any red flag conditions or serious spinal pathology. The patient's prior x-ray did document that the patient had mild spondylolisthesis at the L5 on S1. However, the clinical documentation does not provide any evidence that the patient's symptoms have significantly changed to support the need for an additional x-ray. As such, the prospective request for 1 x-ray of the lumbar spine, flexion/extension between 8/28/2013 and 11/9/2013 is not medically necessary or appropriate.