

Case Number:	CM14-0008633		
Date Assigned:	02/12/2014	Date of Injury:	09/05/2006
Decision Date:	06/30/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/22/2014

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 Orthopedic Surgery, has a subspecialty in Orthopedic Sports 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 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 injured worker is a 50-year-old female who sustained an injury to her low back on 09/05/06 while working as a cashier for [REDACTED]. She was sitting on a barstool when she leaned back slightly, the back of the stool broke. She fell backwards and did not land full and flat on her tailbone, but struck the back of the seat bracket that had become dismembered from the chair itself. The injured worker has had consistent pain ever since the fall. The injured worker reported that after returning home the next day she could not move. She received treatment for approximately two weeks and eventually had an MRI in which findings were negative. She remained off work for five weeks and was sent to physiotherapy for a few months. She was told she had nerve damage following EMG studies and MRI of the SI joints without contrast dated 01/06/09 revealed normal appearance of the bilateral sacroiliac joints. MRI of the lumbar spine dated 01/06/09 revealed no evidence of degenerative disc disease.  

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF LUMBAR SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE PRACTICE GUIDELINES, 2ND EDITION, 2004, CHAPTER 12 (LOW BACK COMPLAINTS), 303-304

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK CHAPTER, MAGNETIC RESONANCE IMAGING

Decision rationale: The request for MRI the lumbar spine is not necessary. The previous MRI of the lumbar spine did not reveal any degenerative disc disease. There was no report of a new acute injury or exacerbation of previous symptoms since the previous imaging study. There was no mention that a surgical intervention was anticipated. Physical examination did not note any decreased motor strength, increased sensory or reflex deficits. There were no focal neurological deficits. There were no physical therapy notes provided for review that would indicate the amount of physical therapy visits the injured worker has completed to date or the injured worker's response to any previous conservative treatment. There were no additional significant 'red flags' identified. Given the clinical documentation submitted for review, medical necessity of the request for MRI lumbar of the lumbar spine has not been established. Recommend non-certification.

SPINAL CORD STIMULATOR TRIAL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, SPINAL CORD STIMULATORS (SCS),

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK CHAPTER, SPINAL CORD STIMULATION (SCS)

Decision rationale: The request for spinal cord stimulator trial is not necessary. There was no psychological evaluation provided for review that would indicate reasonable psychological expectations regarding treatment with a spinal cord stimulator. There were no physical therapy notes provided for review that would indicate the amount of physical therapy visits that the injured worker has completed to date or the injured worker's response to any previous conservative treatment. Given the clinical documentation submitted for review, medical necessity of the request for lumbar spinal cord stimulator trial has not been established. Recommend non-certification.

**LUMBAR EPIDURAL STEROID INJECTIONS L4-5 TRANSFORAMINAL
IPSILATERAL SIDE:** Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, EPIDURAL STEROID INJECTIONS (ESIs),

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESIS) Page(s): 46.

Decision rationale: The request for lumbar epidural steroid injections L4-5 transforaminal ipsilateral side is not medically necessary. The quantity of injections to be administered was not documented. The CAMTUS states that the injured worker must be initially unresponsive conservative treatment including exercises, physical methods, NSAIDs and muscle relaxants. There were no physical therapy notes provided for review that would indicate the amount of physical therapy visits that the injured worker has completed to date or the injured worker's response to any previous conservative treatment. The injured worker also reported that the only injections that had provided any significant relief were piriformis injections. The CAMTUS also states that in the therapeutic phase, repeat blocks should be based on continued objective documented pain improvement including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks. Given the clinical documentation submitted for review: medical necessity of the request for lumbar epidural steroid injections at L4-5 transforaminal ipsilateral side has not been established. Recommend non-certification.