MAXIMUS Federal Services

Case Number:	CM14-0167107		
Date Assigned:	10/14/2014	Date of Injury:	08/08/2006
Decision Date:	12/02/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/10/2014

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 Occupational Medicine and is licensed to practice in Colorado. 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 66 year old male with a date of injury on 8/8/2006 who developed neck and back. He reported this as an injury and was involved in a motor vehicle accident involving cervical whiplash with no other trauma. The injured worker underwent intercostal injections after some time repeat injections were requested in response to denial in a letter of 10/20/14 the treating physician notes that the injured worker was being treated for neuropathic pain stemming from his previous rib fractures that occurred in his pedestrian motor vehicle accident. The injections gave him significant benefit (no visual analog scale [VAS] scores) for several months and his chest pain returned. There are no clinical findings provided and no documentation of functional improvement or decrease in medication usage. Request is for right T5-T12 intercostal injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right T5-T12 intercostal nerve block: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back-Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 49.

Decision rationale: AAfter a professional and thorough review, the above listed issue is not medically necessary. The requested treatment is not medically necessary because it does not meet the criteria of the guidelines for a repeat injection. While the medical note reflects that the injured worker obtained temporary pain relief, there is no documentation of the level of pain relief (via visual analog scale [VAS] scoring required), there is no documentation of functional improvement, no documentation of any decrease in medication usage, and there is no active therapy treatment plan noted for long term management of his chronic pain. The medical treatment guidelines note that injections should be utilized as an adjunct to an active exercise based program and repeat injections are supported only with documentation of substantial (80%) and sustained relief that provided functional improvement and or decrease in medication usage. Therefore, the requested service is considered not medically necessary for the injured worker at this time.