

Case Number:	CM14-0179138		
Date Assigned:	11/03/2014	Date of Injury:	02/03/2014
Decision Date:	12/09/2014	UR Denial Date:	10/03/2014
Priority:	Standard	Application Received:	10/28/2014

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 Internal Medicine 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 injured worker (IW) is a 66-year-old woman who sustained an injury on February 3, 2014. The IW was struck in the back with a tetherball, and had an immediate onset of pain, which continued for several days. Prior treatments have included medications, cold packs, and reclining. The IW underwent aquatic therapy, and chiropractic therapy, which was not helpful. Pursuant to a progress report dated September 17, 2014, the following language was documented under subjective complaints: "It is my impression that her pain persists both on the basis of compression fractures, T12 and/or L1 and that if she were considering a kyphoplasty, which is reasonable to do, based upon persisting pain levels at 8/10, I would work her up further with a bone scan; and if she is hot at one or both levels, we would direct kyphoplasty treatments at those levels". There were no objective physical examination findings documented. Diagnostic impressions reveals: Known newer T12 insufficiency fracture and evidence of prior older L1 fracture; and acknowledged L2-L3 disc degeneration, retrolisthesis and associated left lateral recess and foraminal stenosis. Treatment plan recommendation includes referral for bone scan, IW to review kyphoplasty literature, and let IW consider or pursue epidural steroid injection at left L2-L3.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bone scan with SPECT, lumbar spine: 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) Low Back

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Section; SPECT, Bone Scan

Decision rationale: Pursuant to the Official Disability Guidelines, SPECT bone scan lumbar spine is not medically necessary. The guidelines do not recommend SPECT (single photon emission computed tomography) for general use and back pain. It is under study as screening criteria for facet joint injections or suspected inflammatory arthropathies not diagnosed by more common tests. The decision to use SPECT in most patients with low back pain cannot be supported by clinical trials. Bone scan is not recommended except for bone infection, cancer or arthritis. In this case, the injured worker is a 66-year-old. The injured worker was diagnosed with T 12 compression fracture and a chronic compression fracture of L1. The guidelines do not recommend SPECT for general use and back pain. There are no compelling clinical facts to indicate SPECT is appropriate. Consequently, SPECT bone scan, lumbar spine is not medically necessary. Based on the clinical information in the medical record in the peer-reviewed evidence-based guidelines, SPECT bone scan, lumbar spine.

Left L2-3 Transforaminal epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low back Section, Epidural Steroid Injections

Decision rationale: Pursuant to the Official Disability Guidelines, left L2 - L3 transforaminal epidural steroid injection is not medically necessary. The guidelines set forth the criteria for epidural steroid injection use. They include, but are not limited to, radiculopathy must be documented, objective findings on examination need to be present, radiculopathy must be corroborated by imaging studies and are electrodiagnostic testing; a repeat block is not recommended if there is inadequate response to the first block; injections should be performed using fluoroscopy and injection of contrast for guidance. In this case, the injured workers is a 66-year-old. Prior treatments included cold packs and reclining, chiropractic therapy and aquatic therapy. Chiropractic therapy was not helped. On physical examination, there was no evidence of objective neurologic deficits in a dermatome of distribution consistent with a diagnosis of radiculopathy. Additionally, there were no electrodiagnostic tests to confirm the presence of radiculopathy. Consequently, in the absence of radiculopathy on physical examination and confirmation on electrodiagnostic testing, epidural steroid injections are not medically necessary. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, left L2 - L3 transforaminal epidural steroid injection is not medically necessary.

