

Case Number:	CM14-0043215		
Date Assigned:	07/02/2014	Date of Injury:	01/03/1989
Decision Date:	10/14/2014	UR Denial Date:	03/20/2014
Priority:	Standard	Application Received:	04/10/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in California and Washington. 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 78-year-old male, who reported injury on 01/03/1989. The mechanism of injury was not submitted for review. The injured worker has diagnoses of severe advanced degenerative disc disease, L2-S1; facet arthrosis, L2-S1; foraminal stenosis L2-3 secondary to facet hypertrophy; bilateral sacroiliac joint dysfunction; and, degenerative scoliosis. Past medical treatment consists of physical therapy, ESI, and medication therapy. Medication includes Norco 10/325 one tablet by mouth every 6 hours as needed for pain. An MRI obtained on 02/07/2014 revealed that the injured worker had disc/osteophyte complex with superimposed right lateral recess disc extrusion, which extended 4 mm dorsally and 9 mm proximally along the dorsal aspect of the L2 vertebral body; severe facet arthrosis and ligamentum flavum redundancy; severe canal narrowing; moderate bilateral neural foraminal narrowing (this is at the L2-3 level). On 06/20/2014, the injured worker complained of back pain. Physical examination of the lumbar spine revealed no abnormal curvature. Flexion and extension were limited to about 50% of normal without pain. The injured worker had reproducible tenderness over the facet joints L3-5 bilaterally. Upon examination, it was also noted that the injured worker had a positive Faber test bilaterally, positive shear test bilaterally, positive lateral leg raise bilaterally, and positive tenderness to the PSIS bilaterally. The treatment plan is for the injured worker to undergo additional transforaminal epidural steroid injections at the L2-3 level bilaterally, be issued a lumbar wide corset brace, and have a follow-up appointment. The rationale and Request for Authorization form are not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal epidural steroid injection at L2-3 bilaterally: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESIEpidural steroid injections, Page(s): 46..

Decision rationale: The request for a Transforaminal epidural steroid injection at L2-3 bilaterally is not medically necessary. The California MTUS Guidelines recommends ESI as an option for treatment of radicular pain. An epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is no information on improved function. The criteria for the use of ESI are as follows: Radiculopathy must be documented by physical examination and corroborated by imaging studies, be initially unresponsive to conservative treatment; injections should be performed using fluoroscopy, and no more than 2 nerve root levels should be injected using transforaminal blocks. Submitted documentation lacked evidence of objective findings of numbness, weakness, and loss of strength. There was no radiculopathy documented by the physical examination. Additionally, there was lack of documentation of the injured worker's initial unresponsiveness to conservative treatment, which would include exercise, physical methods, and medications. Furthermore, the MRI of the lumbar spine, dated 02/07/2014, did not indicate that the injured worker had a diagnosis of radiculopathy. Given the above, the injured worker is not within the MTUS recommending guidelines. As such, the request for Transforaminal epidural steroid injection at L2-3 bilaterally is not medically necessary.

Lumbar wide corset brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official disability Guidelines Lumbar supports

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Back Brace, ACOEM, Low Back (physical methods) Page(s): 308.

Decision rationale: The request for Lumbar wide corset brace is not medically necessary. The ACOEM/California MTUS Guidelines state: Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended. There is no medical indication that a back brace would assist in the treatment for the injured worker. As such, the request for a lumbar wide corset brace is not medically necessary.

Re-check appointment with [REDACTED]: Upheld

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

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

Decision rationale: The request for Re-check appointment with [REDACTED] is not medically necessary. The Official Disability Guidelines recommends office visits or follow-up appointments for a proper diagnosis and return to function of an injured worker. The need for a clinical office visit with a healthcare provider is individualized based upon a review of the injured worker's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. As patients' conditions are extremely varied, a set number of visits per condition cannot be reasonably established. Such determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the healthcare system through self-care as soon as clinically feasible. There was no submitted documentation regarding the current clinical situation of the injured worker to determine when he would need to be seen again, and without that information, the necessity of a recheck appointment cannot be determined. Furthermore, findings at an office visit will determine the frequency of the next visit. As such, the request for Re-check appointment with [REDACTED] is not medically necessary.