

<b>Case Number:</b>	CM14-0093602		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	05/01/2001
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	06/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/20/2014

### 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 Nevada. 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 records presented for review, indicate that this 61-year-old female was reportedly injured on 5/1/2001. The mechanism of injury was noted as cumulative trauma. The most recent progress note, dated 5/7/2014, indicated that there were ongoing complaints of neck pain and bilateral shoulder pain. The physical examination demonstrated normal gait. Heel and toe walk performed with difficulty due to low back pain. Cervical spine had decreased lordosis. Mild cervical paraspinal muscle tenderness noted extending to the right trapezius. Axial had compression test positive bilaterally. Spurling sign was positive bilaterally. There was positive tenderness to palpation of the cervical facets from C4-T1. Decreased range of motion was of the cervical spine. Bilateral shoulders had full range of motion. Motor exam was within normal limits 5/5 equal bilaterally. Sensory exam revealed decreased sensation in the right C4-C5 dermatomes. Lumbar spine had positive tenderness to palpation over the lumbar paraspinal muscles and facets from L4-S1. There was decreased range of motion. No recent diagnostic studies are available for review. Previous treatment included medications, and conservative treatment. A request had been made for epidural steroid injection of the cervical spine right side C4-C5 and bilateral C5-C6, MRI of the lumbar spine and lumbar spine brace and was not certified in the pre-authorization process on 6/3/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient right C4-C5 and bilateral C5-C6 Transfacet epidural steroid injections: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESI's).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS; (Effective July 18, 2009) Page(s): 46.

**Decision rationale:** MTUS guidelines support epidural steroid injections when radiculopathy is documented on physical examination and corroborated by imaging and electrodiagnostic studies in individuals who have not improved with conservative care. Based on the clinical documentation provided, and considering the criteria for the use of epidural steroid injections as outlined in the MTUS; there is insufficient clinical evidence presented that the proposed procedure meets the MTUS guidelines. Specifically, there is no documentation of corroborative findings on a diagnostic study. As such, the requested procedure is deemed not medically necessary.

**MRI scan of the lumbar spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** The ACOEM supports the use of MRI for the lumbar spine when there are unequivocal objective findings that identify specific nerve root compromise on exam and the claimant would be willing to consider operative intervention. Based on the clinical documentation provided, there is no documentation of radiculopathy in the bilateral lower extremities on physical exam. Also, the clinician does not document that the claimant is willing to consider operative intervention. As such, secondary to a lack of clinical documentation, the request fails to meet the ACOEM criteria and is not medically necessary.

**Purchase of LSO brace and rental times 30 day trial for electrical muscle stimulation:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** ACOEM treatment guidelines do not support the use of a LSO or other lumbar support devices for the treatment or prevention of low back pain except in cases of specific treatment of spondylolisthesis, documented instability, or postoperative treatment. The claimant is currently not in an acute postoperative setting and there is no documentation of instability or spondylolisthesis with flexion or extension plain radiographs of the lumbar spine. As such, this request is not considered medically necessary.