

Case Number:	CM14-0195777		
Date Assigned:	12/03/2014	Date of Injury:	11/01/1995
Decision Date:	01/20/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	11/21/2014

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 Anesthesiologist,, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 52-year-old male who reported injury on 11/11/1995. The mechanism of injury was not submitted for review. The injured worker has diagnoses of post laminectomy syndrome and osteoarthritis of the right hip. Past medical treatment consisted of surgery, physical therapy, injections and medication therapy. No medications were documented in the report. Diagnostics consist of an x-ray of the lumbosacral spine, which was obtained on 07/21/2014, which revealed persistent advance spondylosis at the L4-5 and L5-S1, with no evidence of instability. There were also signs of facet joint hypertrophy at both levels. On 07/21/2014, the injured worker complained of lower back pain and right hip pain. The injured worker rated the pain at a 7/10. Examination of the lumbar spine revealed a flexion of 90 degrees, extension of 30 degrees, right lateral flexion of 30 degrees, left lateral flexion of 30 degrees, right axial rotation 30 degrees and left axial rotation 30 degrees. There was no tenderness to palpation and spasm at the lumbar and thoracic spine. Reflexes were within normal limits. Motor strength testing revealed a 5/5 in all extremities, except for right hip abductors 4/5 and right anterior tibial 4/5. Sensation to light touch revealed no abnormality. Pinprick sensation testing revealed no abnormality. Straight leg raise, Lasegue's, and Faber test were positive. The medical treatment plan was for retrospective x-ray of the lumbosacral spine and retrospective injection. There was no rationale or Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for x-ray flex/ext. lumbosacral spine (DOS: 7/21/14): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The request for retrospective request for x-ray flex/ext. lumbosacral spine (DOS: 7/21/14) was not medically necessary. The MTUS/ACOEM Guidelines state lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. However, it may be appropriate when the physician believes it would aid in a patient's management. The submitted documentation did not indicate any red flag conditions documented or submitted in the report, nor was there any indication as to how the results of the x-ray would be used to direct future care for the injured worker. Given the above, the injured worker was not within recommended guideline criteria. As such, the request was not medically necessary.

Retrospective request for injection x 8 meds (DOS: 7/22/14): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 14 Ankle and Foot Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid injection Page(s): 46.

Decision rationale: The request for retrospective request for injection x 8 meds (DOS: 7/22/14) was not medically necessary. The California MTUS Guidelines recommend the use of steroid injections as an option for treatment of radicular pain. Criteria for injections: radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing; the patient must be initially unresponsive to conservative treatment; injections should be performed using fluoroscopy for guidance; and if used for diagnostic purposes, a maximum of 2 injections should not be performed. The submitted documentation did not indicate what type of injection the injured worker had undergone. Additionally, the request as submitted did not specify a specific medication, a dosage, nor did it indicate the location of the injection. Given the above, the medical necessity was not established. As such, the request for retrospective injection was not medically necessary.