

Case Number:	CM15-0166837		
Date Assigned:	09/04/2015	Date of Injury:	11/17/2014
Decision Date:	10/09/2015	UR Denial Date:	07/31/2015
Priority:	Standard	Application Received:	08/25/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York, West Virginia, Pennsylvania
 Certification(s)/Specialty: Emergency Medicine

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 39-year-old male, who sustained an industrial injury on November 17, 2014. He reported an injury to his back and his head following a fall. He was diagnosed with a concussion following the incident. Treatment to date has included diagnostic imaging, physical therapy and medications. Currently, the injured worker complains of neck pain, low back pain and thoracic spine pain. He rates his pain a 10 on a 10-point scale. The injured worker reports that his neck pain is in the posterior aspect of his neck and he has occipital radiation of pain. His low back pain radiates to the right lower extremity. On physical examination, the injured worker has a non-antalgic gait. His cervical spine range of motion is satisfactory in all planes and he has a negative Spurling's test. He has restricted range of motion of the lumbar spine and tenderness to palpation along the L4-L5 paraspinals and the spinous process. He has tenderness to palpation along the T6 and T7 region on the right. His motor strength in the bilateral upper extremities and the bilateral lower extremities is intact and he is intact with sensation to light touch. The diagnoses associated with the request include mild traumatic brain injury, cervical strain, lumbago with lumbar disk protrusion, lumbar spondylosis, and thoracic right T6-T7 and T7-T8 right paracentral protrusions. The treatment plan includes focus physical therapy for the lumbar spine, the thoracic spine and the cervical spine; thoracic T6-T7 and T7-T8 thoracic right transforaminal epidural steroid injection, consideration for facet joint injections; and Tramadol, Mobic and Gabapentin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Back Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: Guidelines do not recommend lumbar support for prevention of neck and back pain but may be used in cases of spinal instability or significant spondylolisthesis. In this case, the claimant does not have any spinal instability or spondylolisthesis. The request for a back brace is not medically necessary.

Right Transforaminal 1ST Level 3 sets for 3 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: Guidelines recommend epidural injections as an option when there is radicular pain caused by a radiculopathy documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. The decision to perform repeat epidural steroid injections is based on objective pain and functional improvement, including at least 50% pain relief with reduction in pain medications for 6-8 weeks. In this case, the patient did not have radicular pain. The request for right transforaminal 1st level 3 sets for 3 months is not medically necessary.

Right Transforaminal 2CD Level 3 sets for 3 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: Guidelines recommend epidural injections as an option when there is radicular pain caused by a radiculopathy documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. The decision to perform repeat epidural steroid injections is based on objective pain and functional improvement, including at least 50% pain relief with reduction in pain medications for 6-8 weeks. In this case, the patient did not have radicular pain. The request for right transforaminal 2nd level 3 sets for 3 months is not medically necessary.