

Case Number:	CM15-0010970		
Date Assigned:	01/27/2015	Date of Injury:	08/23/1999
Decision Date:	03/25/2015	UR Denial Date:	12/20/2014
Priority:	Standard	Application Received:	01/16/2015

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: Florida

Certification(s)/Specialty: Neurology, Pain Management

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 53 year old male, who sustained an industrial injury on 8/23/1999. He reports mid neck and low back pain after lifting a box. Diagnoses include cervical, thoracic and lumbar degenerative disc disease with spondylosis, chronic pain syndrome, herniated disc and failed back surgery syndrome, Treatments to date include chiropractic care, prior epidural injections, acupuncture, lumbar 4-5 laminectomy, right shoulder arthroscopic impingement release and anterior fusion of cervical 3-5 and later, cervical 2-7. A progress note from the treating provider dated 11/17/2014 indicates the plan of care included 2 transforaminal epidural injections bilaterally at lumbar 4-5, a transforaminal epidural at cervical 4-5, spinal cord stimulator trial and intrathecal pump trial. On 12/20/2014, Utilization Review non-certified the request for 2 transforaminal epidural injections bilaterally at lumbar 4-5, a transforaminal epidural at cervical 4-5, spinal cord stimulator trial and intrathecal pump trial, citing MTUS.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 Transforaminal epidural steroid injections bilaterally at L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back, Epidural Steroid Injections..

Decision rationale: The medical records provided for review do not document physical exam findings consistent with radiculopathy in association with plan for epidural steroid injection or document objective functional gain or pain improvement in terms of duration or degree in relation to first ESI performed in support of second ESI. ODG guidelines support ESI when (1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. As such the medical records do not support the use of ESI congruent with ODG guidelines.

Tranforaminal epidural at C4-C5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI's.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines neck, ESI.

Decision rationale: The medical records provided for review do not document physical exam findings consistent with radiculopathy in association with plan for epidural steroid injection or document objective functional gain or pain improvement in terms of duration or degree in relation to first ESI performed in support of second ESI. ODG guidelines support ESI when (1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. As such the medical records do not support the use of ESI congruent with ODG guidelines.

Spinal cord stimulator trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulator (SCS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines low back, spinal cord stimulator Page(s): 105.

Decision rationale: MTUS guidelines support spinal cord stimulator trial for patients with condition such as CRPS who have failed at least 6 months conservative treatment and have had psychological evaluation that demonstrates the insured to be a good candidate for the treatment. The medical records indicate condition of CRPS that has not responded to various treatments for greater than 6 months but does not demonstrate documentation of psychological evaluation that

demonstrates the insured to be a good candidate for the treatment. As such spinal cord stimulator is not supported under MTUS.

Intrathecal pump trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Intrathecal drug delivery systems.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, low back, intrathecal pump

Decision rationale: ODG guidelines support intrathecal pump trial for patients with condition such as CRPS who have failed at least 6 months conservative treatment and have had psychological evaluation that demonstrates the insured to be a good candidate for the treatment. The medical records indicate condition of CRPS that has not responded to various treatments for greater than 6 months but does not demonstrate documentation of psychological evaluation that demonstrates the insured to be a good candidate for the treatment. As such intrathecal pump trial is not supported under ODG.