

<b>Case Number:</b>	CM13-0041777		
<b>Date Assigned:</b>	04/25/2014	<b>Date of Injury:</b>	11/13/2012
<b>Decision Date:</b>	07/10/2014	<b>UR Denial Date:</b>	10/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2013

### 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 Neurology has a subspecialty in Neuromuscular Medicine and is licensed to practice in California. 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 patient is a 49-year-old man who sustained a work-related injury on November 13, 2012 the patient developed with chronic neck pain and back pain. According to the progress notes of September 9, 2013 and September 17, 2013, the patient was complaining of neck pain radiating to both upper extremities and lumbar pain radiating to both lower extremities. The pain in the lumbar spine was rated 7.5/10 with numbness and tingling in the left and right foot and weakness in the right leg. The pain is aggravated by constant standing and squatting and repetitive movements as well as prolonged walking. The on physical examination, the patient has an antalgic gait, there is tenderness in the lumbar spine with reduced range of motion, and there is decreased sensation over L4-L5 and S1 dermatoma and decreased strength in the right lower extremity. An EMG/nerve conduction study was performed on April 22, 2013 which demonstrated bilateral chronic active L5 radiculopathy right greater than the left. An MRI of the lumbar spine performed on June 28, 2013 demonstrated multilevel neural foraminal narrowing and spinal canal stenosis and multilevel facet joint hypertrophy. The patient was treated with chiropractic and physical therapy sessions. The no documentation about the pain medications used for this patient. The provider requested authorization for percutaneous spinal root injection and chiropractic manipulation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PERCUTANEOUS SPINAL NERVE ROOT INJECTION AT THE RIGHT L5 AND RIGHT S1 LEVEL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) < Facet joint intra-articular injections (therapeutic blocks).  
[http://www.worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm#Facetjointintraarticularinjections](http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#Facetjointintraarticularinjections).

**Decision rationale:** The patient developed clinical, EMG and MRI findings supportive for the diagnosis of lumbosacral radiculopathy. The patient was already approved for L5-S1 epidural injection. The concurrent request of foraminal block is not medically necessary. Therefore, the request for percutaneous spinal nerve root injection is not medically necessary.

**CHIROPRACTIC MANIPULATION AND ADJUNCTIVE PHYSIOTHERAPY TWO TIMES A WEEK FOR FIVE WEEKS TO THE LUMBAR:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

**Decision rationale:** Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. The patient underwent 8 chiropractic sessions with limited results because of pain. There is no clear justification of more chiropractic sessions. The patient was already approved for physical therapy after lumbar epidural injection. Therefore the requested Chiropractic treatment is not medically necessary.