

<b>Case Number:</b>	CM14-0000833		
<b>Date Assigned:</b>	01/17/2014	<b>Date of Injury:</b>	09/01/2013
<b>Decision Date:</b>	06/06/2014	<b>UR Denial Date:</b>	12/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/02/2014

### 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 Emergency Medicine and is licensed to practice in New York. 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 37-year-old male who was injured on September 1, 2013. The patient continued to experience pain in his lower back, which radiates to his left leg. Physical examination was notable for decreased range of motion of the lumbar spine, positive straight leg raise bilaterally, mild strength deficit secondary to guarding, and intact sensation. MRI of the lumbar spines dated October 18, 2013 reported 3 mm retrolisthesis of L5 on S1 with left paracentral disc extrusion at L5-S1. Diagnoses included lumbar strain and radiculopathy. Requests for authorization for additional chiropractic treatments 6 sessions and lumbar transforaminal epidural steroid injections were submitted for consideration.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **ADDITIONAL CHIROPRACTIC TREATMENTS FOR THE LUMBAR SPINE TWO (2) TIMES THREE (3) WEEKS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Pain Interventions & Guidelines Page(s): 58-60.

**Decision rationale:** Manipulation is 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 therapy 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. It is recommended as an option for low back pain with trials of six visits over 2 weeks. If there is objective evidence of objective improvement, up to 18 visits over 6-8 weeks may be recommended. In this case there is documentation of 12 visits from September to December. During the later 6 visits, there is documentation that the patient is not receiving any improvement. There is no objective evidence of functional improvement documented. The request is not medically necessary and appropriate.

**LUMBAR TRANSFORAMINAL EPIDURAL STEROID INJECTION UNDER FLUOROSCOPY GUIDANCE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural Steroid Injection.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Pain Interventions & Guidelines Page(s): 46.

**Decision rationale:** Epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. In this case the patient did not have objective evidence of radiculopathy. Motor function was symmetrical and sensation was intact. The MRI did not show nerve impingement. There is no objective evidence documented to support the need for epidural steroid injection. Medical necessity has not been established. The request is not medically necessary and appropriate.