

Case Number:	CM14-0105269		
Date Assigned:	07/30/2014	Date of Injury:	08/27/2012
Decision Date:	09/30/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/08/2014

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 Family 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:

This is a 40 year old male with an 8/27/2012 date of injury. The exact mechanism of the original injury was not clearly described. A progress reported dated 5/21/14 noted subjective complaints of neck, shoulder, and thoracic spine pain. Objective findings included thoracic spinal tenderness, decreased ROM. Thoracic MRI 1/23/14 showed diffuse disc protrusions. There is a disc protrusion at T8-9 which mildly compresses the ventral aspect of the cord. It was noted that the patient underwent six chiropractic treatments and did not feel that it was of much benefit. It is noted that the patient is currently able to work full time. Diagnostic Impression: thoracic strain, multilevel thoracic disc protrusions with mild cord compression Treatment to Date: chiropractic, medication management, TENS. A UR decision dated 6/17/14 denied the request for additional chiropractic therapy x 6 for thoracic spine. The guidelines require evidence of functional improvement for the continuation of chiropractic care. The patient previously completed chiropractic care and noted no benefit. It also denied a spine surgery consultation. The documentation does not support the need of additional specialist involvement in the current clinical setting as the current objective finding do not suggest that additional expertise is necessary. It also denied thoracic epidural injection (levels not specified) with fluoroscopy and sedation. Documentation does not indicate that the patient has exhausted conservative treatment modalities. The physical exam does not provide objective findings to support the need for an ESI. Therefore, the request is considered not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Six (6) Additional Chiropractic Therapy Sessions for the Thoracic Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that with evidence of objective functional improvement with previous treatment and remaining functional deficits, a total of up to 18 visits are supported. In addition, Elective/Maintenance care is not medically necessary. However, it is noted that the patient has had 6 prior chiropractic sessions and specifically documented that it did not help him at all. It is unclear why additional sessions would be of benefit. Therefore, the request for Six Additional Chiropractic Therapy Sessions for the Thoracic Spine was not medically necessary.

Spinal Surgery Consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, Independent Medical Examinations and Consultations.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter, American College of Occupational and Environmental Medicine (ACOEM) Chapter 6 - Independent Medical Examinations and Consultations pages 127, 156.

Decision rationale: CA MTUS states that Consultations are recommended, and a health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. However, there is no mention of an uncertain diagnosis. There is no documentation that imminent surgery might be necessary. In fact, the patient is still able to work full time. Additionally, conservative therapy with Physical Therapy is still being continued. Therefore, the request for Spinal Surgery Consultation was not medically necessary.

Thoracic Epidural Injection with Fluoroscopy and Sedation (levels not specified): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: AMA guides (Radiculopathy).

Decision rationale: CA MTUS does not support Epidural Injections in the absence of objective radiculopathy. In addition, CA MTUS criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology; and conservative treatment. Furthermore, repeat blocks should only be offered if there is at least 50-70% pain relief for six to eight weeks following previous injection, with a general recommendation of no more than 4 blocks per region per year. Online resource defines sedation as the reduction of irritability or agitation by administration of sedative drugs, generally to facilitate a medical procedure or diagnostic procedure. However, the patient has yet to complete a course of aggressive conservative therapy. Also, there is no clear documentation of any physical exam deficits consistent with thoracic radiculopathy. Furthermore, there is no specified level(s) or laterality for the proposed treatment. Therefore, the request For Thoracic Epidural Injection with Fluoroscopy and Sedation (levels not specified) was not medically necessary.