MAXIMUS Federal Services

Case Number:	CM14-0011746		
Date Assigned:	02/21/2014	Date of Injury:	08/19/2011
Decision Date:	08/05/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	01/29/2014

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 Anesthesiology has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 39-year-old female who has submitted a claim for L3-L4 and L4-L5 disc protrusion with annular tear at L4-L5 and lumbar facet syndrome, possible SI joint dysfunction, right greater trochanteric bursitis, sleep dysfunction, and depression; associated with an industrial injury date of 08/09/2011. Medical records from 2013 to 2014 were reviewed and showed that patient complained of low back pain, graded 7/10. Physical examination showed that patient was alert and oriented x3, in moderate distress, but was cognitively intact. Range of motion to the lumbar spine was limited to pain. Motor and sensory testing was normal. Treatment to date has included medications, Imitrex injections, physical therapy, acupuncture, chiropractic therapy, cognitive behavioral therapy, and epidural steroid injection. Utilization review, dated 01/23/2014, denied the request for epidural steroid injection because there was no evidence of radicular pain in a dermatomal distribution with corroborated objective findings, and the request did not specify the treatment levels; and modified the request for chiropractic therapy to 6 sessions because it was deemed reasonable to address pain and deficits.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR EPIDURAL STEROID INJECTION.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection Page(s): 46.

Decision rationale: As stated on page 46 of the CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injections (ESI) are recommended as an option for treatment of radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Also, the patient must be initially unresponsive to conservative treatment. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks. In this case, the patient complains of low back pain despite conservative therapy. However, the medical records submitted for review did not indicate radiculopathy on physical examination, and did not include imaging or electrodiagnostic evidence of radiculopathy. The patient has had previous ESI; however, there was no discussion regarding duration or percentage of pain relief or objective evidence of functional improvement from previous ESI. Lastly, the present request as submitted failed to specify the level and laterality of the intended procedure. The criteria for ESI have not been met. Therefore, the request for lumbar epidural steroid injection is not medically necessary.

CHIROPRACTIC SESSIONS FOR THE LOW BACK, QTY 12: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy Page(s): 58-60.

Decision rationale: As stated on pages 58 to 60 of the CA MTUS Chronic Pain Medical Treatment Guidelines, manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. The intended goal or effect of manual medicine is the achievement of functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. In addition, the ODG recommends an initial trial of 6 visits over 2 weeks, up to 18 visits over 6-8 weeks for the lower back. In this case, patient complained of low back pain despite conservative treatment. However, physical examination showed only limited lumbar range of motion. There was no discussion regarding current functional deficits or limitations in ADLs. Furthermore, the total number of previous chiropractic sessions, as well as objective evidence of functional improvement derived from these sessions was not provided. Therefore, the request for chiropractic sessions for the low back, qty 12 is not medically necessary.