

Case Number:	CM14-0011884		
Date Assigned:	02/21/2014	Date of Injury:	08/10/2011
Decision Date:	08/07/2014	UR Denial Date:	01/13/2014
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 28-year-old male who has submitted a claim for thoracic sprain/strain, lumbar sprain/strain; degenerative joint disease, and radiculopathy, sciatic tract neuritis; associated with an industrial injury date of 08/10/2011. Medical records from 2012 to 2014 were reviewed and showed that patient complained of thoracic and lumbar spine, and bilateral leg pain. Patient also noted numbness that radiates from the buttocks down the lateral aspect of the leg and foot. Physical examination showed that patient had difficulty getting off of his chair, and had an antalgic gait. Range of motion of the lumbar spine was limited to pain. DTRs were normal. Motor testing showed weakness of the bilateral lower extremities. Decreased sensation was noted over the left leg and abdominal region. MRI of the lumbar spine, dated 01/09/2012, showed right neural foraminal narrowing at the right S1 level. EMG/NCV of the bilateral lower extremities, dated 01/08/2013, showed mild denervation potentials in the right S1 myotome with prolonged right H reflex consistent with mild right S1 radiculopathy. Treatment to date has included medications, physical therapy, and chiropractic therapy. Utilization review, dated 01/13/2014, denied the request for epidural steroid injection and chiropractic therapy due to lack of documentation to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural Steroid Injection Of The Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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 California 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. In this case, the patient complains of back and leg pain accompanied by radicular symptoms despite medications and physical therapy. Physical examination showed hypoesthesia over the left leg, and bilateral lower extremity weakness. EMG/NCV of the bilateral lower extremities, dated 01/08/2013, showed mild right S1 radiculopathy, and MRI of the lumbar spine, dated 01/09/2012, showed right S1 neural foraminal narrowing. However, physical examination failed to show objective evidence of radiculopathy. Moreover, MRI of the lumbar spine, dated 01/09/2012, failed to specify the degree of right S1 neural foraminal narrowing or show nerve root compromise. 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 Epidural Steroid Injection of the Lumbar Spine is not medically necessary.

Chiropractic Physiotherapy Three Times A Week For Two Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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 California 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, the patient has had previous chiropractic therapy. However, the medical records submitted for review failed specify the total number of sessions attended, and show objective evidence of functional improvement derived from these sessions. Moreover, there was no discussion regarding current functional deficits. Lastly, the present request as submitted failed to specify body part to be treated. Therefore, the request for Chiropractic Physiotherapy three times a week for two weeks is not medically necessary.