

Case Number:	CM14-0151402		
Date Assigned:	09/19/2014	Date of Injury:	12/29/2009
Decision Date:	10/22/2014	UR Denial Date:	09/11/2014
Priority:	Standard	Application Received:	09/17/2014

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 Internal Medicine, has a subspecialty in Nephrology 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 62-year-old female who has submitted a claim for lumbar radiculitis and degeneration of lumbar disc associated with an industrial injury date of 12/29/2009. Medical records from 04/22/2014 to 09/03/2014 were reviewed and showed that patient complained of low back pain radiating down bilateral lower extremities. Physical examination revealed restricted lumbar spine ROM, weakness of left quadriceps, hypoesthesia along left L4 and L5 dermatomal distribution, and positive SLR test bilaterally at 30 degrees. MRI of the lumbar spine dated 02/25/2014 revealed L5-S1 proximal neurocompression. Treatment to date has included 6 visits of chiropractic care, bilateral L4-5 TFESI (06/30/2014), and pain medications. Unquantified pain relief for less than 2 weeks on the left and unspecified duration on the right side was noted with previous TFESI. Objective documentation of functional outcome with chiropractic care was not made available. Utilization review dated 09/11/2014 denied the request for Left L4-L5 Transforaminal Epidural Steroid Injection because there was no documentation of at least 50% pain relief with previous ESI. Utilization review dated 09/11/2014 denied the request for 6 chiropractic sessions because there was no objective documentation from previous chiropractic treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Sessions QTY 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 59-60.

Decision rationale: According to CA MTUS Chronic Pain Treatment Guidelines, manual therapy such as chiropractic care 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. The recommended initial therapeutic care for low back is a trial of 6 visits over 2 weeks, with evidence of objective functional improvement. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Chiropractic care is not recommended for other body parts other than low back. In this case, the patient completed 6 visits of chiropractic care. However, there was no documentation of functional outcome with previous visits to support continuation of treatment. Moreover, the request failed to indicate the body part to be treated. Therefore, the request for Chiropractic Sessions QTY 6 is not medically necessary.

Left L4-L5 Transforaminal Epidural Steroid Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

Decision rationale: The CA MTUS Chronic Pain Treatment Guidelines recommend ESIs as an option for treatment of radicular pain. Most current guidelines recommend no more than 2 ESI injections. 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. ESIs do not provide long-term pain relief beyond 3 months and do not affect impairment of function or the need for surgery. The criteria for use of ESIs are: Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing; Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants); Injections should be performed using fluoroscopy (live x-ray) for guidance; 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 six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. In this case, the patient underwent bilateral L4-5 TFESI on 06/30/2014. The patient was not able to quantify pain relief that lasted for less than 2 weeks on the left side. The guidelines recommend at least 50% pain reduction that is sustained for six to eight weeks prior to approval of repeat ESI. The request likewise failed to specify if ESI would be done under fluoroscopic guidance per guidelines requirement. Therefore, the request for Left L4-L5 Transforaminal Epidural Steroid Injection is not medically necessary.

