

Case Number:	CM14-0033893		
Date Assigned:	06/20/2014	Date of Injury:	01/23/2008
Decision Date:	09/17/2014	UR Denial Date:	03/07/2014
Priority:	Standard	Application Received:	03/18/2014

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 Occupational 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:

The patient is a 40-year-old female who has submitted a claim for lumbago, degeneration of lumbar or lumbosacral intervertebral disc, sciatica, and myalgia and myositis associated with an industrial injury date of 01/03/2008. Medical records from 08/05/2013 to 03/07/2014 were reviewed and showed that patient complained of low back pain radiating down the lower extremities with associated weakness. Physical examination revealed misalignment in the lumbar paraspinal muscles and decreased lumbar ROM (range of motion). Neurologic and bilateral lower extremity evaluations were not made available. MRI of the lumbar spine dated 11/20/2010 revealed L4-5 disc protrusion with mild facet joint arthropathy in moderate central canal stenosis with no neural foraminal stenosis in moderate right neural foraminal stenosis, L3-4 disc protrusion with mild facet joint arthropathy and L4 upon L5 retrolisthesis and incidental left synovial cyst at L4-5 level. Treatment to date has included at least 10 visits of chiropractic treatment and acupuncture. Of note, 20% pain reduction was noted with chiropractic treatment (01/14/2014). Utilization review dated 03/07/2014 denied the request for epidural steroid injection bilateral L4-5 because there were no objective physical exam findings to corroborate with MRI findings and no failure of response to conservative treatment. Utilization review dated 03/07/2014 modified the request for chiropractic/decompression treatment 1x per week for 12 weeks to 1x per week for 4 weeks as trial basis since there was objective evidence of functional improvement from previous chiropractic treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

EPIDURAL STEROID INJECTION @ BILATERAL L4-5: 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 rehabilitation 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. In this case, the patient complained of low back pain radiating down the lower extremities with associated weakness. MRI of the lumbar spine was done on 11/20/2010 with evidence of moderate L4-5 right neural foraminal stenosis. However, neurologic and bilateral lower extremities evaluation was not made available to support the presence of radiculopathy. There was documentation of improvement with chiropractic treatment (03/07/2014). Hence, physical exam findings did not corroborate with MRI findings and failure of conservative treatment was not present to support ESI. Furthermore, the request failed to indicate if the ESI was to be done under fluoroscopic guidance per guidelines recommendation. Therefore, the request for Epidural Steroid Injection @ Bilateral L4-5 is not medically necessary.

CHIROPRACTIC/DECOMPRESSION TREATMENT- ONE (1) TIME A WEEK FOR TWELVE (12) WEEKS: 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 noted a 20% pain reduction from previous chiropractic treatment. Four additional visits of chiropractic

treatment were certified on 03/07/2014. However, there was no documentation of functional improvement with recent chiropractic treatment in order to support the continuation of chiropractic care. Therefore, the request for Chiropractic/Decompression Treatment- One (1) Time a week for Twelve (12) weeks is not medically necessary.