

<b>Case Number:</b>	CM14-0044887		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	07/30/2012
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	04/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/11/2014

### 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 Physical Medicine and Rehabilitation 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 records indicate the applicants last day of work was July 30, 2012. He is receiving disability benefits. Thus far, treatment has consisted of pain management, lumbar steroid injection and chiropractic physiotherapy which provided moderate relief. He also treated with TENS. MRI of the lumbar spine dated September 11, 2012 revealed findings of an L5/S1 disc bulge eccentric to the right with a superimposed right posterior paracentral disc protrusion. The protrusion contacts and impinges and compresses both exiting right L5 nerve root and transiting right S1 nerve root. L4/5 there is a broad based bulge, L3/4 disc bulge and a grade I anterolisthesis of L5 on S1 as well as a bilateral L5 pars defect. In review of pain management soap note dated January 6, 2014 (prior to the performance of the lumbar steroid injection), there were complaints of lower back pain with intermittent radiation to bilateral lower extremities, occasional in frequency and mild in intensity. Examination revealed a decrease in the ranges of motion of the lumbar spine, there was no lumbar spine asymmetry of lumbar spine or scoliosis, normal alignment with lordosis, tenderness on palpation over the bilateral lumbar paraspinal muscles with spasm, sciatic notch tenderness. In review of pain management soap note dated 2/17/14, the doctor requests "continued conservative management for complaints of low back pain including a trial of therapeutic spinal injection, based on failure to improve with conservative treatment and positive MRI findings". The doctor then goes on and states continued chiropractic physiotherapy would be recommended as this has been significantly helpful in reducing the patient's symptomology. The applicant underwent a lumbar epidural steroid injection, lumbar epidurography, fluoroscopy on January 28, 2014 with postprocedural diagnoses of lumbosacral radiculitis. Upon review of follow-up pain management soap note dated March 31, 2014, the steroid injection to the lumbar spine that was performed on 1/28/14 resulted in a reduction in pain, improved overall function, reduced reliance on pain medications and improved quality of sleep. He does continue to have

lower back pain with intermittent radiating to bilateral lower extremity, which is occasional in frequency and mild in intensity. Pain is increase with his activities of daily living and his job. His pain is aggravated by bending forward, backwards, prolonged standing and walking. It is relieved by rest and lying down. The record indicated the applicant was not working or doing physical exercise due to pain. The examination findings revealed a restriction in lumbar ranges of motion, normal alignment with normal lumbar lordosis, there is tenderness over the bilateral lumbar paraspinal muscles consistent with spasm, negative straight leg raise bilaterally, negative lumbar facet loading maneuver, no gluteal spasm and no piriformis spasm. Muscle strength is graded 5/5 bilaterally of the lower extremities with normal tone with the exception of 4/5 on the left ankle plantar flexion and left great toe extension. Diminished sensation in the left L5 and S1 dermatomes of the lower extremities, reflexes are symmetric. The applicant was diagnosed with displacement of lumbar intervertebral disc without myelopathy. A lumbar steroid injection was performed at the L5/S1 level with 25% improvement. The applicant is unable to do his regular job at the tire shop. A request was for chiropractic treatment two times per week for five weeks for a total of 10 visits. Trazodone 50mg was prescribed for sleep problems. The applicant was temporarily totally disabled pending completion of requested treatment. Upon review of pain management examination report dated June 6, 2013 regarding causation, impairment and future medical treatment recommendations. The applicant was evaluated due to a work related injury on a cumulative basis from July 30, 2011-July 30, 2012 and injuries sustained to the lower back, both legs, both knees, both ankles and both feet. The treatment recommendations were as follows: anti-inflammatory medication, pain medication, muscle relaxants and sleeping aids on an as needed basis, epidural steroid injection and lumbar interbody decompression, discectomy and fusion of L5/S1. It must be noted, that chiropractic physiotherapy treatment was not part of the future medical care recommendations. In review of utilization report dated 4/8/14 the reviewer indicated that the requested outpatient chiropractic treatment to the low back two times per week for five weeks was non-certified. The reviewer documents the applicant is post epidural steroid injection with improved pain, although there is recurrence of ongoing back pain. The reviewer indicated it was not clear why the patient would be on an active independent home program as recommended by ACOEM and ODG guidelines at this point in care. Upon review of a rebuttal dated 5/6/14 with regards to the necessity of 10 chiropractic physiotherapy sessions, the medical doctor indicated the applicant is a candidate as it is recommended by the guidelines and refers to the CA MTUS 2009 Chronic Pain Medical Treatment Guidelines page 58 as well as treatment parameters from State Guidelines.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Outpatient chiropractic treatment to the low back, two (2) times per week over (5) five weeks.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines web-based edition [http://www.dir.ca.gov/t8/ch4\\_5sb1a5\\_5\\_2.html](http://www.dir.ca.gov/t8/ch4_5sb1a5_5_2.html)\*

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8.C.C.R. 9792.20-9792.26 MTUS Manual Therapy & Manipulation Chapter, pages 58-60 Page(s): 58-60.

**Decision rationale:** The MTUS Chronic Pain Chiropractic guidelines indicate that manual therapy and manipulation for low back is recommended with evidence of functional improvement as well as a successful return to work. The applicant, as per the records, has not returned to work since July 30, 2012. The guidelines note if return to work is achieved then 1-2 visits every 4-6 months are recommended. In fact, the reason the lumbar steroid epidural injection was requested was due to the fact that prior conservative treatment has failed. The guidelines indicate that elective maintenance care is not medically necessary. There was no indication of any exacerbations/flair ups or re-injuries noted. Therefore the request is not medically necessary.