

Case Number:	CM14-0051734		
Date Assigned:	07/07/2014	Date of Injury:	03/23/2007
Decision Date:	12/25/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/21/2014

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 & Rehabilitation, has a subspecialty in Interventional Spine Pain Management 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 37-year-old female with injury date of 03/23/07. Based on the 02/20/14 progress report, the patient complains of increasing pain in left Iliolumbar ligament with radiation down the left lower extremities. Physical examination to the lumbar spine revealed tenderness to palpation to the left Iliolumbar ligament and decreased range of motion. Positive straight leg raise test on the left. Per progress report dated 02/26/14, provider requests epidural steroid injections of left L4, L5 and S1, and chiropractic care. The patient has been able to work full duties as per 02/20/14 progress report. Diagnostic test: (per UR letter dated 03/21/14) was MRI of the lumbar spine 05/30/07: slight broad-based bulge at L4-5. Diagnoses are Left lumbosacral strain; Left lumbosacral radiculopathy; Left paracervical strain and Right shoulder impingement. The utilization review determination being challenged is dated 03/21/14. The rationale for epidural steroid injection: "Radiculopathy must be documented on physical examination. The medical records do not clearly outline such symptoms, exam findings, and diagnostics to correlate to support the presence of specific radiculopathy, at 1 or 2 levels as requested at this time. Therefore, the request is not medically necessary." The rationale for chiropractic treatment: "this chronic injury which is over 7 years old, this treatment request appears to be maintenance in nature. Therefore, the request is not medically necessary at this time." Treatment report was from 02/20/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L4-L5, L5-S1 epidural steroid injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46 and 47.

Decision rationale: The patient presents with increasing pain in the "left Iliolumbar ligament with radiation down the left lower extremities." The request is for Left L4-L5, L5-S1 Epidural Steroid Injection. Patient's diagnosis dated 02/20/14 includes left lumbosacral strain and left lumbosacral radiculopathy. Examination of lumbar spine on 02/20/14 revealed left Iliolumbar ligament tenderness, decreased range of motion, and positive left straight leg raise test. MRI of the lumbar spine dated 05/30/07 revealed slight broad-based bulge at L4-5, per UR letter dated 03/21/14. MTUS Guidelines, pages 46-47: Criteria for the use of Epidural steroid injections: "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In this case, while the patient has pain down the left leg, the distribution of pain is not described in a specific dermatomal pattern to suspect radiculopathy. While examination shows positive SLR, MRI shows only bulging disc and no potential nerve root lesion on the symptomatic left side to consider an ESI. MTUS require a clear diagnosis of radiculopathy which is not provided in this case. Therefore, this request is not medically necessary.

Chiropractic treatment two timer per week for four weeks to lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58 and 59.

Decision rationale: The patient presents with increasing pain in the "left paracervical trapezius muscle area," and "left Iliolumbar ligament with radiation down the left lower extremities." The request is for Chiropractic Treatment two times per week for four weeks to lumbar, "to help with pain management," per report 2/20/14. MTUS Guidelines pages 58-59 states, "Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary." In this case, the review of the reports does not show Chiro treatments in the recent past. A short trial course of 6 sessions are consistent with MTUS recommendations but the requested 8 sessions are excessive without documentation of prior treatments showing functional improvement. Therefore, this request is not medically necessary.