

Case Number:	CM14-0187737		
Date Assigned:	11/18/2014	Date of Injury:	08/28/2007
Decision Date:	01/06/2015	UR Denial Date:	11/10/2014
Priority:	Standard	Application Received:	11/11/2014

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 Emergency Medicine, and is licensed to practice in Texas. 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 injured worker is a 53-year-old female who reported injury on 08/28/2007. The mechanism of injury was continuous trauma. Her diagnoses included right greater than left L5 and S1 radiculopathy, confirmed by EMG dated 12/21/2010, L3-S1 degenerative disc disease and annular fissure, L4-S1 central canal stenosis and neural foraminal stenosis, facet hypertrophy at L3-S1, lateral right meniscus tear, medial right meniscus tear, chondromalacia of the right patella, right knee Baker's cyst, and right greater trochanter bursitis. The past treatments included physical therapy, chiropractic therapy, medications, and corticosteroid injection to the right greater trochanter with Celestone and Marcaine. An MRI of the lumbar spine, dated 04/03/2014, revealed lumbar spondylosis at L3 through S1 with severe degenerative changes at L4-5 and L5-S1, a 5 mm disc protrusion at L5-S1, and moderate narrowing of the neural foramen bilaterally. An x-ray of the spine revealed approximately 14 degrees of scoliosis of the thoracolumbar spine. A lumbar discogram, dated 09/08/2014, reported a negative discogram at L2-3, positive discogram at L3-4, L4-5, and L5-S1. The surgical history was not provided. The progress note, dated 10/17/2014, noted the injured worker complained of low back pain radiating into her right buttock and hip, down her anterior and posterior thigh bilaterally, and pain in her right calf. She rated her pain a 9/10 with medication and a 10/10 without medications. The physical exam revealed tenderness to palpation over the L4-5 and L5-S1 bilaterally, decreased sensation was noted to the bilateral L5 and S1 dermatome distributions, deep tendon reflexes of the bilateral lower extremities were rated 2+, and motor strength was rated 5/5 except for the bilateral extensor hallucis longus was 4/5. The physician provided a right greater trochanter injection of Celestone and Marcaine, and recommended chiropractic therapy twice a week for 3 weeks and acupuncture therapy twice a week for 3 weeks, and to consider decompression at the bilateral

L4-5 and L5-S1 if no improvement. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 2 x 3 weeks, lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture 2 x 3 weeks, lumbar spine is not medically necessary. The California MTUS Acupuncture Guidelines recommend acupuncture as an option when pain medications are reduced or not tolerated, or as an adjunct to physical therapy or surgical intervention to hasten recovery. The guidelines state acupuncture treatments should produce functional improvement in 3 to 6 treatments and if there is evidence of significant objective functional improvement at the initial trial, the guidelines recommend continuation of treatment with 1 to 3 sessions a week over 1 to 2 months. There is a lack of documentation of intolerance to her medications. There is no documentation indicating active therapy is or will be utilized. As such, the use of acupuncture is not indicated or supported by the evidence based guidelines at this time. Therefore, the request is not medically necessary.

Chiropractic manipulation 2 x 3 weeks, lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 58.

Decision rationale: The request for chiropractic manipulation 2 x 3 weeks, lumbar spine is not medically necessary. The California MTUS Guidelines state that chiropractic care for pain, if caused by musculoskeletal conditions is recommended. 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 injured worker's therapeutic exercise program, and return to productive activities. The guidelines recommend a trial of 6 visits over 2 weeks and with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks. There is a lack of evidence of functional deficits to the spine which would benefit from chiropractic treatment. The injured worker was reported to have had chiropractic treatment previously. It is not clear when or the amount of chiropractic visits the injured worker had. There is a lack of documentation indicating the injured worker had significant objective functional improvement with the prior therapy. There is no documentation indicating active therapy is or will be utilized. Given the above, the request for 6 additional chiropractic sessions

is not indicated and is possibly excessive at this time. Therefore, the request is not medically necessary.

Trochanter Corticosteroid Injection with 3cc of Celestone and 3cc of Marcaine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip & Pelvis Chapter, Trochanteric Bursitis Injections

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, Trochanteric bursitis injections

Decision rationale: The request for trochanter corticosteroid injection with 3cc of Celestone and 3cc of Marcaine is not medically necessary. The Official Disability Guidelines recommend trochanteric bursitis injections for trochanteric pain. Steroid injections should be offered as a first line treatment of trochanteric bursitis, particularly in older adults. The use of a combined corticosteroid-anesthetic injection typically results in rapid, long lasting improvement in pain and disability. There is no documentation provided indicating current trochanteric pain/bursitis. There is a lack of documentation of the effectiveness of previous injections. As such, the use of a trochanteric corticosteroid injection is not indicated or supported by the evidence based guidelines at this time. Therefore, the request is not medically necessary.