

Case Number:	CM14-0087163		
Date Assigned:	07/23/2014	Date of Injury:	12/09/2012
Decision Date:	04/16/2015	UR Denial Date:	05/07/2014
Priority:	Standard	Application Received:	06/11/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 46 year old female, who sustained an industrial injury on 12/9/12. The injured worker has complaints of neck pain and bilateral wrist and hand pain, left more than right. Electromyogram impression showed mild right median sensory demyelinating neuroathy across the wrist, mild right carpal tunnel syndrome; mild left ulnar sensory demyelinating neuropathy across the wrist and no evidence of cervical radiculopathy on either side. The diagnoses have included neck pain and bilateral wrist pain and paresthesias. According to the utilization review performed on 5/7/14, the requested Chiropractic 2x4 and Injection x3 lumber Spine Epidural has been non-certified. California Medical Treatment Utilization Schedule (MTUS), Chronic Pain Medical Treatment Guidelines were used in the utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 2x4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: Based on the 03/18/14 progress report provided by treating physician, the patient presents with low back pain rated 7.5/10 that radiates to the right leg. The request is for CHIROPRACTIC 2X4. RFA not provided. Patient's diagnosis on 03/18/14 included lumbar spine herniated nucleus pulposus; facet arthropathy; disc bulge L5/S1 (2mm); right lower extremity radiculopathy, greater than left; and right carpal tunnel syndrome greater than left. Patient's medications include Gabapentin and Ibuprofen. Patient is temporarily totally disabled, per treater report dated 03/18/14. MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. MTUS page 8 also requires that the treater monitor the treatment progress to determine appropriate course of treatments. Treater has not provided reason for the request. Given patient's continued symptoms, diagnosis, and no reference to a recent course of chiropractic care, a short course would be indicated by guidelines. However, the current request for 8 sessions exceeds what is allowed by MTUS. Therefore, the request IS NOT medically necessary.

Injection x3 lumbar Spine Epidural: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46, 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47.

Decision rationale: Based on the 03/18/14 progress report provided by treating physician, the patient presents with low back pain rated 7.5/10 that radiates to the right leg. The request is for INJECTION X3 LUMBAR SPINE EPIDURAL. Patient's diagnosis on 03/18/14 included lumbar spine herniated nucleus pulposus; facet arthropathy; disc bulge L5/S1 (2mm); right lower extremity radiculopathy, greater than left; and right carpal tunnel syndrome greater than left. Patient's medications include Gabapentin and Ibuprofen. Patient is temporarily totally disabled, per treater report dated 03/18/14. The MTUS Guidelines has the following regarding ESI under chronic pain section page 46 and 47, "Recommended as an option for treatment of radicular pain." MTUS has the following criteria regarding ESI's, under its chronic pain section: Page 46,47 "1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 8) Current research does not support a 'series-of-three' injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections." For repeat ESI, MTUS states, "In the therapeutic phase, 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." The patient presents with low back pain with radicular symptoms and a diagnosis of radiculopathy. Physical examination to the lumbar spine on 03/18/14 revealed tenderness to palpation and decreased range of motion.

Positive straight leg raising test on the left and reduced sensation to light touch at the left L5-S1 distribution. MRI of the lumbar spine dated 04/16/13 revealed "1) Normal overall canal size without any posterior protrusion or broad-based disc bulging 2) No lateral recess or foraminal narrowing. No nerve root impingement 3) Slight changes of facet arthropathy developing at L4-5 and L5-S1 4) minimal posterior disc bulge of less than 2mm without stenosis at L5-S1." In this case, treater has documented radiculopathy supported by physical examination; however, imaging study does not corroborate with findings. MTUS requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Furthermore, the request for a series of 3 injections is not supported by MTUS. Moreover, treater has not indicated levels nor sides to be injected. The request does not meet guideline criteria for the procedure. Therefore, the request IS NOT medically necessary.