

<b>Case Number:</b>	CM15-0020440		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	07/26/2013
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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: Ohio, North Carolina, Virginia  
Certification(s)/Specialty: Family Practice

### 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 male, who sustained an industrial injury on 07/26/2013. He has reported low back pain. The diagnoses have included lumbar herniated nucleus pulposus with stenosis at L5-S1, lumbar radiculopathy, and lumbar facet arthropathy. Treatments have included medication, physical therapy, and chiropractic sessions. Medications have included Gabapentin, Cyclobenzaprine, and Norco. Currently, the IW complains of low back pain, rated at 6-7/10 on the visual analog scale; muscle spasms in the low back; and numbness in the bilateral posterior thighs, with tingling radiating down to his feet. A progress note from the treating physician, dated 01/12/2015, reported objective findings to include a slow and antalgic gait; tenderness to palpation over the lower lumbar facet regions bilaterally and in the lumbar paraspinous regions; and severe pain with facet loading of the lumbar spine. The treatment plan included request for additional chiropractic treatment at two times a week for four weeks; and request a transforaminal epidural injection on the left at L5 and S1. On 01/29/2015 Utilization Review noncertified a prescription for 8 sessions of chiropractic, 2x4, for the lumbar spine; and for Transforaminal epidural injection left L5 & S1. The CA MTUS, ACOEM and the ODG were cited. On 02/03/2015, the injured worker submitted an application for 8 sessions of chiropractic, 2x4, for the lumbar spine; and for Transforaminal epidural injection left L5 & S1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**8 sessions of chiropractic, 2x4, for the lumbar spine: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, Chronic Pain Treatment Guidelines Chiropractic treatment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back

**Decision rationale:** Manipulation is recommended as an option for low back pain. Medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. For patients with chronic low back pain, manipulation may be safe and outcomes may be good, but the studies are not quite as convincing. While not proven by multiple high quality studies, a trial of manipulation for patients with radiculopathy may also be an option, when radiculopathy is not progressive, and studies support its safety. ODG Chiropractic Guidelines: Therapeutic care Mild: up to 6 visits over 2 weeks. Severe: Trial of 6 visits over 2 weeks. Severe: With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, if acute, avoid chronicity. Elective/maintenance care Not medically necessary. Recurrences/flare-ups Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care. Severe may include severe sprains/strains (Grade II-III1) and/or non-progressive radiculopathy (the ODG Chiropractic Guidelines are the same for sprains and disc disorders) In this instance, the injured worker has had 8 sessions of chiropractic care with evidence of functional improvement in terms of increased ability to walk and the need for less medication. His radiculopathy appears to be non-progressive. Therefore, 8 sessions of chiropractic, 2x4, for the lumbar spine are medically necessary.

**Transforaminal epidural injection left L5 & S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back

**Decision rationale:** The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. (1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. (4) Diagnostic Phase: At the time

of initial use of an ESI (formally referred to as the “diagnostic phase” as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections. (5) No more than two nerve root levels should be injected using transforaminal blocks. (6) No more than one interlaminar level should be injected at one session. (7) Therapeutic phase: If after the initial block/blocks are given (see Diagnostic Phase above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007) (8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. (9) Current research does not support a routine use of a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment. (10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. (11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.) In this instance, the injured worker had lumbar epidural steroid injection(s) in 2014 and has reported no relief of pain. Additional epidural steroid blocks are indicated if the initial block allows 50-70% pain relief for 6-8 weeks. That does not appear to be the case here. Therefore, Transforaminal epidural injection left L5 & S1 is not medically necessary in view of the submitted medical record and with reference to the cited guidelines.