

Case Number:	CM15-0125796		
Date Assigned:	07/10/2015	Date of Injury:	11/06/2006
Decision Date:	08/06/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	06/29/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 52-year-old female who sustained an industrial injury on 11/6/06. She had complaints of low back pain. Treatments include: medication, physical therapy, chiropractic, electrical muscle stimulation, myofascial release, infra red therapy, epidural injections and surgery. Pain management progress report dated 6/5/15 reports continued complaints of chronic pain in the low back and lower extremities. Diagnoses include: post lumbar laminectomy failed back syndrome and abnormal gait. Plan of care includes: refill prescriptions, chiropractic evaluation and treatment, therapeutic lumbar epidural injection L5-S1 and evaluation and treatment with pain management psychologist. Follow up in 1 month.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy evaluation and treatment for ten session, QTY: 10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

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

Decision rationale: The claimant has a remote history of a work-related injury and continues to be treated for radiating low back pain including a diagnosis of post-laminectomy syndrome. When seen in March 2015, there was radiating low back pain to the right lower extremity with numbness. A CT scan of the lumbar spine in June 2012 had shown findings of moderate to severe right L5/S1 foraminal narrowing with post-surgical scarring. Physical examination findings included decreased lumbar range of motion and difficulty transitioning positions. Prior examinations document decreased right lower extremity strength. Chiropractic care is recommended as an option in the treatment of chronic pain. Guidelines recommend a trial of 6 visits over 2 weeks with further treatment considered if there is objective evidence of functional improvement and with a total of up to 18 visits over 6-8 weeks. In this case, the number of initial treatment sessions requested is in excess of the guideline recommendation and not medically necessary.

Psychotherapy, cognitive behavioral therapy evaluation and treatment for ten session for the lumbar spine, QTY: 10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines, Cognitive Behavioral Therapy (CBT) for chronic pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Cognitive behavioral therapy (CBT).

Decision rationale: The claimant has a remote history of a work-related injury and continues to be treated for radiating low back pain including a diagnosis of post-laminectomy syndrome. When seen in March 2015, there was radiating low back pain to the right lower extremity with numbness. A CT scan of the lumbar spine in June 2012 had shown findings of moderate to severe right L5/S1 foraminal narrowing with post-surgical scarring. Physical examination findings included decreased lumbar range of motion and difficulty transitioning positions. Prior examinations document decreased right lower extremity strength. In term of cognitive behavioral therapy, guidelines recommend an initial trial of 6 visits over 6 weeks and with evidence of objective functional improvement, a total of up to 13-20 individual sessions over 7-20 weeks. In this case, the number of requested treatments is in excess of the guideline recommendation and this request was not medically necessary.

Steroid lumbar epidural with fluoroscopy and monitored anesthesia: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 45-46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections, Page(s): 46. Decision based on Non-MTUS Citation Statement on Anesthetic Care during Interventional Pain Procedures for Adults. Committee of Origin: Pain Medicine (Approved by the ASA House of Delegates on October 22, 2005 and last amended on October 20, 2010).

Decision rationale: The claimant has a remote history of a work-related injury and continues to be treated for radiating low back pain including a diagnosis of post-laminectomy syndrome. When seen in March 2015, there was radiating low back pain to the right lower extremity with

numbness. A CT scan of the lumbar spine in June 2012 had shown findings of moderate to severe right L5/S1 foraminal narrowing with post-surgical scarring. Physical examination findings included decreased lumbar range of motion and difficulty transitioning positions. Prior examinations document decreased right lower extremity strength. Criteria for the use of epidural steroid injections include that radiculopathy be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, the claimant's provider documents decreased right lower extremity strength and imaging is reported as showing corroborating findings of right lumbar radiculopathy. However, monitored anesthesia is also being requested for the procedure. In this case, there is no documentation of a medically necessary reason for monitored anesthesia during the procedure being requested. There is no history of movement disorder or poorly controlled spasticity such as might occur due to either a spinal cord injury or stroke. There is no history of severe panic attacks or poor response to prior injections. There is no indication for the use of sedation and this request is not medically necessary.