

Case Number:	CM15-0175901		
Date Assigned:	09/17/2015	Date of Injury:	04/17/2011
Decision Date:	10/26/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	09/08/2015

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: North Carolina

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 68 year old male with an industrial injury dated 07-17-2011. Medical record review indicate he is being treated for right knee sprain and pain, right knee status post total knee replacement, lumbar disc herniation and lumbar sprain. The progress report dated 04-06-2015 documented the injured worker presented with complaints of right knee and low back pain with radiation to the bilateral lower extremities with sensorimotor deficit and weakness in the lower extremities. Physical exam performed on 04-06-2015 revealed well-healed scar tissue from total right knee replacement. The range of motion had decreased to the extent "that the knee just bends up to 90 degree" with "severe" tenderness in the knee area. Examination of the lumbar spine is documented as revealing painful flexion and extension with "severe" tenderness in the lumbar paraspinal muscles. Bilateral straight leg raise test was positive and range of motion of the lumbar spine was decreased. This report does not indicate a numeric pain rating. The treatment plan included continuation of transdermal cream and ibuprofen, lumbar epidural steroid injection, physical therapy and chiropractic treatment and consultation with an orthopedic surgeon. The injured worker was "temporarily totally disabled for six weeks." The progress note dated 03-09-2015 documented "MRI of the lumbar spine revealed the following: At lumbar 3-lumbar 4 there is a 4 mm disc bulging." "At lumbar 4-lumbar 5 there is a 3 mm disc bulging." The lower back pain was rated as 7 out of 10 and the right knee pain was rated as 8 out of 10 in the 03-09-2015 note. Prior treatment is documented as a right total knee replacement and medications. The treatment request is for lumbar epidural steroid injection at lumbar 4-5 and lumbar chiropractic (no frequency-duration.). On 08-25-2015, the request for lumbar epidural steroid injection at lumbar 4-5 and lumbar chiropractic (no frequency-duration) was deemed not medically necessary by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection at L4-L5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and 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) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 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. The patient has the documentation of back pain however there is no included imaging or nerve conduction studies in the clinical documentation provided for review that collaborates dermatomal radiculopathy found on exam for the requested level of ESI. Therefore, criteria have not been met and the request is not medically necessary.

Lumbar chiropractic (no freq/dur): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The California chronic pain medical guidelines section on manual manipulation states: "recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. 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 patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. 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. Recurrences/flare-ups: Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines a. Time to produce effect: 4 to 6 treatments." Manual manipulation is recommended form of treatment for chronic pain. However the requested amount of therapy sessions is in excess of the recommendations per the California MTUS. The California MTUS states there should be not more than 6 visits over 2 weeks and documented evidence of functional improvement before continuation of therapy. The request does not specify a frequency or duration. This does not meet criteria guidelines and thus is not medically necessary.