

Case Number:	CM13-0024937		
Date Assigned:	12/11/2013	Date of Injury:	01/12/2012
Decision Date:	02/27/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	09/16/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 physician 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.

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 patient is a 41-year-old female who reported an injury on 01/12/2012. The patient was diagnosed with facet arthropathy, a herniated nucleus pulposus of the lumbar spine, cervical radiculopathy, chronic pain syndrome and right lumbar radiculopathy. The patient was seen by [REDACTED] on 11/20/2013. The patient reported 9/10 neck pain as well as lower back pain with radiation to the bilateral lower extremities. Physical examination revealed an antalgic gait, decreased range of motion of the cervical and lumbar spines, positive "facet challenge" to the right L5-S1 level, tenderness to palpation of the right L5-S1 facet region, intact sensation in the bilateral upper and lower extremities, 5/5 motor strength throughout and a positive Spurling's maneuver bilaterally. Treatment recommendations included the continuation of current medications, facet injections to the right L5-S1 and interlaminar epidural steroid injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interlaminar epidural steroid injection at C5-C6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 46.

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

Decision rationale: The California MTUS Guidelines recommend epidural steroid injections as an option for the treatment of radicular pain with use in conjunction with other rehab efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. As per the clinical notes submitted, the patient underwent an MRI of the cervical spine on 04/17/2013, which indicated no neural foraminal narrowing at any level. The patient's physical examination revealed only tenderness to palpation with limited range of motion. The patient demonstrated intact sensation in the bilateral upper extremities as well as 5/5 strength. There was no documentation of radicular symptoms upon physical examination or imaging studies. There was also no evidence of a failure to respond to recent conservative treatment, including exercises, physical methods, NSAIDs and muscle relaxants. Based on the clinical information received, the request is non-certified.

Transforaminal lumbar epidural steroid injection right L5 and S1 Roots: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 46.

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

Decision rationale: The California MTUS Guidelines state that epidural steroid injections are recommended as an option for the treatment of radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. As per the clinical notes submitted, the patient's physical examination on the requesting date of 11/05/2013 only revealed tenderness to palpation with decreased range of motion. The patient demonstrated intact sensation with 5/5 motor strength. There was no documentation of radicular symptoms upon physical examination. Additionally, there were no imaging studies or electrodiagnostic reports submitted for review. There was no evidence of this patient's unresponsiveness to recent conservative treatment, including exercises, physical methods, NSAIDs and muscle relaxants. Based on the clinical information received, the request is non-certified.

Acupuncture 1 x 8 for the bilateral wrists: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California MTUS Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated and may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The time to produce functional improvement includes 3 to 6 treatments with a frequency of 1 to 3 times per week. As per the clinical notes submitted, there is no documentation of a physical examination of the

wrists or hands. Therefore, there is no evidence of a significant musculoskeletal or neurological deficit. The goals of acupuncture treatment have not been clearly defined. There was no indication that the patient has reduced or is not tolerating her pain medication. Additionally, the request for 8 sessions of acupuncture treatment for the bilateral wrists exceeds the guideline recommendations. Therefore, the request is non-certified.