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| Case Number: | CM13-0039293 | | |
| Date Assigned: | 12/18/2013 | Date of Injury: | 04/04/2001 |
| Decision Date: | 03/05/2014 | UR Denial Date: | 10/04/2013 |
| Priority: | Standard | Application Received: | 10/04/2013 |

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 Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California. 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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant is a 53-year-old female employed as a correctional officer. She was first injured on the job on April, 4 2001 after a mattress was thrown from a second-story tier by another officer and landed on her head. She suffered both head and neck injuries. Approximately one year later, in April 2002, her primary treating physician reviewed her x-rays and it was discovered that she had actually suffered from a crushed cervical vertebrae, and she eventually underwent cervical fusion. After her surgery and rehabilitation she was allowed to return to work on a light duty status and after approximately six months she was returned to full duty status with no restrictions. She reports that although she suffered from residual pain, and limited range of motion difficulties, she continues to work in a full duty status. She reports that she enjoyed her job and working in the prison environment and had no issues with her job performance. Her second industrial injury occurred on September 6, 2011. At that time, her job entailed responding to emergencies and alarms on the yards, building and preparing reports, and escorting and supervising inmates. She shared that on her date of injury she was in the process of doing a security check of a facility and as she entered the building she slipped on the floor and skidded to a hard stop, due to the floor at the entrance being wet. She indicated she flailed about to keep her balance and in the process felt she had strained several muscles and experienced immediate pain to her neck, shoulder, and right arm. She did report this injury to her immediate supervisor and sought treatment from her primary care physician shop laved her in a TTD disability status. She indicated that she was initially informed that there was some slippage in her original fusion that she had to her neck secondary to her industrial injury that occurred in April 2001. Currently she reports that she continues to experience ongoing difficulties secondary to her industrial injuries in that she experiences neck and head pain, right shoulder pain, left arm and hand numbness, coupled with reoccurring lower back pain and pain that radiates down her left leg. This is

coupled with a generalized tingling like sensation and numbness to her hands, arms, and neck. She also indicated that her strength, mobility, and coordination has been impaired as well as she has a notable reduction in her physical endurance. She also shared that she has experienced a varying weight and appetite, reduced libido, and her symptoms of anxiety and depression have persisted. She indicated that since our last evaluation she has not experienced any significant changes or improvements in her medical or psychiatric condition. She currently remains in a TTD status and receives continued palliative treatments and medications prescribed by her primary care physician, and it is her understanding that she may require a cervical disc surgical procedure in the future. For clarification, the specific injury of April 4, 2001 (ADJ2038440) is for neck, upper and lower back, and headaches; the specific injury of September 6, 2011 (ADJ8065826) is for neck, left shoulder, left arm, and left hand. The cumulative trauma injury is for high blood pressure, psyche, and headaches. She shared that she continues to experience depressive symptomatology which includes sadness, apathy, and that she "feels empty inside". She indicated that she is socially isolative and is prone to episodic crying. She shared that she experienced continued limited range of motion difficulties, has reduced physical endurance and is easily fatigued. Also since the prior evaluation in February 2012 with this consultant her symptoms have persisted and have remained unchanged. She also shared that on a consistent basis she experiences symptoms of anxiety and depression. She also reports that she worries about her health all the time. She reports memory and concentration difficulties and that she loses focus

IMR ISSUES, DECISIONS AND RATIONALES

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

eight physical therapy sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

Decision rationale: The California MTUS Chronic Pain Medical Treatment guideline, section of Physical Medicine, page 99 allows for fading of treatment (from up to 3 visits per week to 1 or less), plus active self-directed home physician medicine. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or

without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007). According to medical records reviewed, the claimant has received over 80 sessions of physical therapy with a temporary benefit; therefore the request for 8 sessions of physical therapy is not medically necessary.

2nd lumbar epidural steroid injection L4-L5: Upheld

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

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

Decision rationale: The California MTUS (Effective July 18, 2009) Chronic Pain Medical Treatment Guidelines (page 46), stipulates that "the purpose of Epidural Steroid Injections (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". Occupational Medicine Treatment Guidelines (page 300) stated "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. The medical records reviewed indicated that the claimant complained of neck pain radiating to the arms, legs that got worse. She received epidural injection in August 2013, and there is no continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks as stipulated by the guidelines, therefore the request for 2nd lumbar epidural steroid injection L4-L5 is not medically necessary.

2nd lumbar epidural steroid injection L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Section Page(s): 46.

Decision rationale: The California MTUS (Effective July 18, 2009) Chronic Pain Medical Treatment Guidelines (page 46), stipulates that "the purpose of Epidural Steroid Injections (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". Occupational Medicine Treatment Guidelines (page

300) stated "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. The medical records reviewed indicated that the claimant complained of neck pain radiating to the arms, legs that got worse. She received epidural injection in August 2013, and there is no continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks as stipulated by the guidelines, therefore the request for 2nd lumbar epidural steroid injection L5-S1 is not medically necessary.