

Case Number:	CM13-0042168		
Date Assigned:	03/28/2014	Date of Injury:	03/21/2009
Decision Date:	04/28/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	10/17/2013

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. The expert reviewer is Board Certified in Orthopedic Surgery 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 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/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 patient is a 42 year old female who was injured on 03/21/2009. The mechanism of injury is unknown. Treatment history included medication, physical therapy, ESIs, and left wrist arthroscopy. Diagnostic studies reviewed include: X-rays, 4 views including dynamic flexion and extension, of the lumbar spine revealed narrowing at L4-L5. There is mild retrolisthesis. The L5-S1 level appears to be vestigial with clear evidence of sacralization. MRI scan of the lumbar spine performed on 05/23/2013 revealed disc desiccation at L4-L5. I do not see any evidence of annular tearing. There is disc protrusion present. There is no severe stenosis. Ultrasound right elbow performed 09/30/2013 revealed mild tendinosis of the origin of the common flexor tendon evidenced by mild thickening and mild hypoechogenicity, as described above, when compared to the contra lateral side. MRI of the lumbar spine without contrast performed on 07/22/2013 revealed: Posterior lumbar interbody fusion at L3-4 and L4-5 with metallic transpedicular screws present; Posterior decompression at L4; Postsurgical changes are nonspecific swelling are demonstrated within the dorsal lower lumbar soft tissue, T12-L1, a 2.8 mm anterior disc bulge is noted, L1-2 a 2.5 mm anterior disc bulge and bilateral facet arthrosis are noted. Grade 1 retrolisthesis of L2; L2-3, bilateral facet arthrosis and moderate bilateral neural foraminal narrowing are noted. L3-4 bilateral facet arthrosis and mild bilateral neural foraminal narrowing is noted. L4-5, bilateral facet arthrosis and moderate bilateral neural foraminal narrowing are noted. Grade 1 retrolisthesis of L5; L5-S1, bilateral facet arthrosis and marked bilateral neural foraminal narrowing are noted. Supplemental Report dated 03/27/2013 indicated the patient incurred a cumulative trauma injury. She experienced gradual worsening of her left wrist residuals, 5/10 and worsening. Inspection of the left upper extremity reveals a well-healed portal scars consistent with the history of 2003 arthroscopy. There is tenderness diffusely over the left forearm and wrist flexor and extensor muscles and tendons exacerbated by

passive and resisted wrist flexion and extension. There is also tenderness over the lateral-greater-than medial epicondyles of the elbow. Cozen's and reverse Cozen's tests are positive for increased lateral and medial epicondyle pain, lateral side greater than medial side. Tinel's over the elbow ulnar groove and bent-elbow test are negative. Tinel's over the wrist carpal tunnel and tunnel of Guyon is negative; Phalen's is negative. There is tenderness over the left first extensor compartment; Finkelstein's test is positive for increased left first extensor compartment pain. There is diffuse decreased sensitivity to pinprick and light touch over the left third through fifth digits in an ulnar nerve distribution. With the exception of decreased sensitivity to pinprick and light touch over the left third through fifth digits in an ulnar nerve distribution, neurological examination of the left upper extremity is intact. Orthopedic spinal surgery Re-evaluation report dated 07/10/2013 documented the patient to have complaints of continued pain in her back region to her left lower extremity. Objective findings on exam revealed lumbar paraspinals are tender; flexion is approximately 60 degrees and extension is 20 degrees; Extension causes a great deal more pain than flexion. On the left side, the FABER maneuver is positive. There is no significant leg pain with straight leg raise maneuver or passive internal rotation of the hip, neither with active external rotation, neither produces severe leg pain. There has been no change in the patient's neurological examination of the lower extremities. The patient was diagnosed with L5-S1 disc desiccation without severe stenosis and left lower extremity radiculopathy. This patient has persistent pain in her back radiating to her left lower extremity. She certainly has not improved as has expected with the excellent and well-directed non-invasive treatment made available for her over the years, including rest, therapy, medication and epidural steroid injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

FUNCTIONAL RESTORATION PROGRAM, 2 TIMES A WEEK FOR 4 WEEKS:

Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs) Page(s): 49.

Decision rationale: According to the CA MTUS guidelines, FRPs, a type of treatment included in the category of interdisciplinary pain programs (see Chronic pain programs) were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. The medical records document the patient has chronic low back, left wrist, and bilateral upper extremity pain. The request is for 4 weeks of FRP; however, the guidelines indicate that the treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. Thus, the request is not medically necessary according to the guidelines.

PHYSICAL THERAPY FOR THE RIGHT WRIST, 2 TIMES A WEEK FOR 3 WEEKS:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: According to the CA MTUS Guidelines, Physical Medicine is recommended as a modality of treatment that can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. The medical records submitted are not completely legible. There is no documentation about prior treatment to the right wrist or physical examination of the right wrist. Thus, the request for 2x 3 weeks of physical therapy to right wrist is not medically necessary.

ACUPUNCTURE FOR THE RIGHT ELBOW/WRIST: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to the CA MTUS guidelines, Acupuncture Medical Treatment is recommended as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The medical records submitted did not indicate that this patient is actively participating in a physical therapy program or that surgery is under consideration. Additionally, the request is for acupuncture for the right elbow/wrist; with no mention on the duration or frequency. The medical necessity for acupuncture (right elbow) has not been established.

LUMBAR SPINE MECHANICAL TRACTION UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Traction.

Decision rationale: The CA MTUS guidelines do not specifically mention the issue therefore, the ODG was utilized. According to the ODG, lumbar spine mechanical traction unit is recommended as a home-based noninvasive conservative option, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration. As a sole treatment, traction has not been proved effective for lasting relief in the treatment of low back pain. The medical records document the patient had complained of low back pain with radiation

to left lower extremity, objective findings on exam revealed paraspinal tenderness with limitation of range of motion. In the absence of documentation of active adjunctive conservative program, the request is not medically necessary according to the guidelines.

ULTRASOUND GUIDED CORTISON INJECTION TO THE LEFT HIP: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hips & Pelvis, Intra-Articular Steroid Hip Injection (IASHI).

Decision rationale: The CA MTUS guidelines remain silent on intrarticular steroid hip injection. According to the ODG, "Not recommended in early hip osteoarthritis (OA). Under study for moderately advanced or severe hip OA, but if used, should be in conjunction with fluoroscopic guidance. Recommended as an option for short-term pain relief in hip trochanteric bursitis." The medical records document the patient had history of left hip sprain as a result of a work injury on 02/21/2009. The recent progress notes are not completely legible and there is no documentation of objective findings and prior treatment to left hip. In the absence of established diagnosis of left hip trochanteric bursitis and osteoarthritis, the request is not medically necessary.

