

Case Number:	CM13-0069575		
Date Assigned:	01/03/2014	Date of Injury:	06/15/2010
Decision Date:	08/08/2014	UR Denial Date:	11/28/2013
Priority:	Standard	Application Received:	12/23/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 57-year-old female with date of injury of 06/15/2010. The listed diagnoses dated 11/04/2013 are: Tension headache., Cervical spine sprain and strain., History of contusion of the right shoulder., Lumbar spine sprain/strain., Degenerative disk disease with intermittent lower radiculopathy., Status post total hip replacement., Internal derangement of the bilateral knees., and Sleep difficulties, anxiety, and distress. According to this report, the patient complains of severe pain on the left side of the back in her ribcage. The patient reports low back pain and knee pain. She reports depression and crying spells due to medical condition affecting her daily function. The objective findings show the lumbar spine is tender to palpation. There are muscle spasms present. There is limited range of motion. Cervical spine presents with tenderness and pain. There is diffuse tenderness to palpation on the shoulder with restricted range of motion. The knees have some slight swelling and pain. The utilization review denied the request on 11/28/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

EPIDURAL STEROID INJECTION: L3-L5 X2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines The Medical Treatment Utilization Schedule has the following regarding ESI's, under its chronic pain section: Page 46,47 Page(s): 46, 47.

Decision rationale: This patient presents with low back pain, shoulder pain, and neck pain. The physician is requesting an epidural steroid injection at L3-L5 x2. The MTUS Guidelines page 46 and 47 on epidural steroid injection states that it is recommended as an option for treatment of radicular pain, as defined by pain in a dermatomal distribution with corroborative findings in an MRI. For repeat blocks, continued objective documented pain and functional improvement should include at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks with a general recommendation of no more than 4 blocks per region per year. The records show that the patient underwent an epidural steroid injection of the lumbar spine on March 2013 which gave her temporary relief. The MRI of the lumbar spine dated 07/02/2013 shows a 4- to 5-mm left-sided protrusion to L3-L4 and a 5-mm disk protrusion at L4-L5. In this case, the patient's previous ESI provided only temporary relief. In addition, the progress report following the patient's epidural steroid injection documents continued use of medication and increase in back pain symptoms and no leg symptoms. Given the lack of functional improvement following an epidural steroid injection, repeat injections cannot be authorized. Recommendation is for denial.

MRI: THORACIC SPINE: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177, 178.

Decision rationale: This patient presents with low back pain, shoulder pain, and neck pain. The treater is requesting an MRI of the thoracic spine. The ACOEM Guidelines page 177 to 178 list the criteria for ordering imaging studies which include emergency of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery in clarification of anatomy prior to this procedure. ACOEM further states that unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence toward imaging studies if symptoms persist. The progress report dated 11/04/2013 notes muscle spasms and tenderness in the lumbar spine with limited range of motion. There is also tenderness and pain noted at the cervical spine with no new neurologic deficits or nerve root lesions were noted. However, the patient has pain in ribcage, which may be radiating pain from thoracic spine due to a nerve root lesion. MRI would be appropriate and consistent with ACOEM guidelines recommendations. Recommendation is for authorization.

POST OPERATIVE PHYSICAL THERAPY 3X3: Upheld

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

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

Decision rationale: This patient presents with low back pain, shoulder pain, and neck pain. The treater is requesting a postoperative physical therapy x9. The MTUS Guidelines page 98 and 99 on physical medicine recommends 8 to 10 visits for myalgia, myositis, neuralgia-type symptoms. Based on the utilization review, it appears that the request is following the patient's epidural steroid injection. Given that the ESI has been denied, postoperative physical therapy is not warranted. Recommendation is for denial.

MEDICATION: VOLTAREN 75MG #60: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain (MTUS 60, 61) Page(s): 60-61.

Decision rationale: This patient presents with low back pain, shoulder pain, and neck pain. The treater is requesting Voltaren 75mg. The MTUS Guidelines page 22 on anti-inflammatory medications states that these medications are the traditional first line treatment to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. None of the 143 pages of records document a history of Voltaren use. It appears that the treater is initiating NSAID use. In this case, the patient continues to present with low back, shoulder and neck pain that the use of NSAID is recommended as first line therapy to reduce pain and inflammation. Recommendation is for authorization.

FACET INJECTION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the MTUS American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, 2nd Edition, (2004), Chapter 12 Low Back Complaints, page 300-301 and on the Non-MTUS Official Disability Guidelines (ODG).

Decision rationale: This patient presents with low back pain, shoulder pain, and neck pain. The treater is requesting a facet injection. For facet blocks, ACOEM Guidelines do not support facet injections as treatment, but does discuss dorsal medial branch blocks and RF ablations on page 300 and 301. For a more thorough discussion on facet joint diagnostic evaluations, ODG Guidelines are consulted. ODG Guidelines does support facet diagnostic evaluations for patients presenting with paravertebral tenderness with non-radicular symptoms and no more than 2 levels bilaterally are to be injected. The MRI report dated 07/02/2013 notes a 5-mm protrusion centrally to the right at L4-L5. There is also a 4 to 5-mm protrusion extension posteriorly at L3-L4. In this case, while the patient presents low back pain with non-radicular symptoms, the treater failed to specify the level to be injected. While L3-L4 and L4-L5 may be appropriate, it is unclear from the documents provided which levels the treater wants injected. Recommendation is for denial.