

<b>Case Number:</b>	CM13-0070062		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	06/05/2013
<b>Decision Date:</b>	08/08/2014	<b>UR Denial Date:</b>	12/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/24/2013

### 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 Emergency Medicine and is licensed to practice in New York. 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 year-old female who was injured on June 5, 2013. The patient continued to experience pain in her neck and bilateral wrists. Physical examination was notable for paravertebral cervical muscular tenderness, intact motor strength, intact sensation to all extremities and tenderness to the upper extremities. Diagnoses included upper extremity radiculopathy, rule out herniated nucleus pulposus of the cervical spine, rule out herniated nucleus pulposus of the cervical spine, pain bilateral wrists, and internal derangement of the left knee. Treatment included occupational therapy, physical therapy, home exercises, and medications. Requests for authorization for physical therapy visits #6, pain management consultant, ESI, and chiropractic therapy visits # 6 were submitted for consideration.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **PHYSICAL THERAPY X 6: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Pain Interventions and Guidelines Page(s): 98-99.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, TENS units, ultrasound, laser treatment, or biofeedback. They can provide short-term relief during the early phases of treatment. Active treatment is associated with better outcomes and can be managed as a home exercise program with supervision. ODG states that physical therapy is more effective in short-term follow up. Patients should be formally assessed after a six-visit clinical trial to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. In this case the patient had already received 8 visits of physical therapy. The recommended number of physical therapy visits for myalgia /myositis or neuralgia/neuritis is 10. The requested number of visits would bring the total to 14. This number surpasses the recommended maximum of visits. The request should not be authorized.

**PAIN MGMT CONSULT:** 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 Other Medical Treatment Guideline or Medical Evidence: UpToDate; Evaluation of Chronic Pain in Adults.

**Decision rationale:** Many patients with chronic pain may be managed without specialty referral. Patients may require referral to a pain specialist for the following reasons: -Symptoms that are debilitating-Symptoms located at multiple sites-Symptoms that do not respond to initial therapies-Escalating need for pain medication In this case the documentation does not support that the indications for pain management consultation have been met. Not all initial therapies have been tried and failed. There is no escalating need for pain medication. The request should not be authorized.

**ESI CONSULT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESI'S) Page(s): 46.

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

**Decision rationale:** Epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Most current guidelines recommend no more than 2 ESI injections. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is

little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. In this case the physical examination does not support the diagnosis of radiculopathy. Medical necessity has not been established. The request should not be authorized.

**6 VISITS CHIROPRACTIC:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 58.

**Decision rationale:** Manual therapy and evaluation are 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. Recommended treatment parameters are as follows: Time to produce effect - 4-6 treatments, frequency of 1-2 times per week with maximum duration of 8 weeks. In this case the patient had received 6 occupational therapy visits and 8 physical therapy visits. There is no documentation of objective evidence of functional improvement. The request should not be authorized.