

<b>Case Number:</b>	CM14-0008756		
<b>Date Assigned:</b>	02/12/2014	<b>Date of Injury:</b>	11/16/2011
<b>Decision Date:</b>	06/25/2014	<b>UR Denial Date:</b>	12/31/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/22/2014

### 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 Pain Management 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:

This is a patient with a date of injury of 11/16/11. A utilization review determination dated 12/31/13 recommends non-certification of PT and a repeat ESI. It notes that 12 PT sessions have been completed. 12/18/13 medical report identifies neck and left upper extremity pain and paresthesias. Pain in the right neck and shoulder has slightly gotten worse. On exam, cervical spine ROM is limited, spasms are palpable. 6 PT sessions were recently finished and found to be extremely helpful. Epidural in the past has been helpful and provided significant resolution of the symptoms.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY 1-2 TIMES PER WEEK FOR 6 WEEKS CERVICAL:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 20.

**Decision rationale:** Regarding the request for Physical Therapy 1-2 times per week for 6 weeks cervical, California Chronic Pain Medical Treatment Guidelines, cites that "patients are

instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." Within the documentation available for review, there is documentation of completion of prior PT sessions that were noted to be helpful, but there is no documentation of specific objective functional improvement with the previous sessions or why any remaining deficits cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the California Chronic Pain Medical Treatment Guidelines, supports only up to 10 PT sessions for this injury 12 PT sessions have already been completed. In light of the above issues, the currently requested Physical Therapy 1-2 times per week for 6 weeks cervical is not medically necessary.

**REPEAT C7-T1 INTERLAMINAR EPIDURAL STEROID INJECTION WITH FLUOROSCOPIC GUIDANCE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, CHAPTER EPIDURAL STEROID INJECTIONS (ESI) ,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines 9792.20-9792.26 EPIDURAL STEROID INJECTIONS (ESIS) Pag.

**Decision rationale:** Regarding the request For Repeat C7-T1 Interlaminar Epidural Steroid Injection with Fluoroscopic Guidance, Chronic Pain Medical Treatment Guidelines, cites that ESI is recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy), and radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Regarding repeat epidural injections, guidelines state that repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. Within the documentation available for review, prior ESI was noted to be helpful and provided significant resolution of the symptoms. However, there is no documentation of radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing as well as continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks from the prior injection. In the absence of such documentation, the currently requested Repeat C7-T1 Interlaminar Epidural Steroid Injection with Fluoroscopic Guidance is not medically necessary.