MAXIMUS Federal Services

Case Number:	CM14-0014374		
Date Assigned:	02/26/2014	Date of Injury:	04/05/2009
Decision Date:	06/27/2014	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	02/04/2014

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 and Pain Management, 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 56-year-old female with date of injury of 04/05/2009. The listed diagnoses per [redacted] dated 12/17/2013 are: 1. Major depressive disorder. 2. Chronic pain. 3. Degenerative lumbosacral intervertebral disk. 4. Spinal stenosis of the lumbar region. 5. Thoracic/lumbosacral neuritis/radiculitis unspecified. 6. Knee pain. According to this report, the patient presents with lumbar pain, bilateral leg symptoms, and left knee pain. The physical exam shows there is marked tenderness in the left lumbar paraspinal area with marked tenderness in the right lumbar paraspinal area as well. No kyphosis, lordosis, or scoliosis were noted. Movement is really restricted in all directions. Pain elicited in all directions. There is moderate prepatellar bursa tenderness, moderate anterior medial joint line tenderness, moderate popliteal fossa tenderness in the left lower extremity. Strength of the major groups is 4/5. There is moderate generalized knee edema on the right. There is generalized moderate crepitation on the right knee as well. Muscle strength of the major group is 5/5 on the right. There is impaired sensation to touch and pinprick in the L5 distribution bilaterally. Gait is antalgic favoring the left. The patient uses a cane to ambulate. Deep tendon reflexes are normal and symmetrical reflexes, hyporeflexic on the lower extremities. There is a positive straight leg raise on the left at 15 degrees. Positive straight leg raise on the right at 45 degrees. The utilization review denied the request on 12/31/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL ESI FROM L5-S1: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines THE MEDICAL TREATMENT UTILIZATION SCHEDULE HAS THE FOLLOWING REGARDING ESI'S, UNDER ITS CHRONIC.

Decision rationale: This patient presents with chronic back pain with bilateral lower extremity symptoms. The treater is requesting a bilateral epidural steroid injection for L5-S1. The MTUS Guidelines page 46 and 47 on epidural steroid injection states that it is recommended as an option for treatment of radicular pain (defined as pain in the dermatomal distribution with collaborative findings of radiculopathy). The MRI of the lumbar spine dated 12/23/2010 showed severe spinal stenosis at L5-S1 and moderate central and foraminal stenosis at L4-5. The examination dated 12/17/2013 documents positive straight leg raise with impaired sensation to touch and pain at the L5 distribution bilaterally. Records do not show ESI history and a trial of an injection would appear reasonable given the patient's leg symptoms, stenosis at multi-level and physical examination findings. The request is medically necessary and appropriate.

AQUA THERAPY 2-3 TIMES PER WEEK FOR 4-6 WEKS TO TREAT LUMBAR, SACRAL AND BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines AQUATIC THERAPY, 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines AQUATIC THERAPY; PHYSICAL MEDICINE Page(s): 22; 98, 99.

Decision rationale: This patient presents with chronic back pain with bilateral lower extremity symptoms. The treating physician is requesting 18 aquatic therapy sessions for the lumbosacral and bilateral lower extremities. The MTUS Guidelines recommends aquatic therapy as an option for land-based physical therapy in patient that could benefit from decreased weight bearing such as extreme obesity. For the number of treatments, MTUS physical medicine section states that 8 to 10 sessions of physical therapy are indicated for various myalgias and neuralgias. The review of 239 pages of records do not show any recent or prior aquatic therapy reports to verify how many treatments and with what results were accomplished. The utilization review denied the request stating that the patient had 24 physical therapy sessions with not much improvement. The progress report dated 06/10/2013 documents that there are no changes in the musculoskeletal exam. She continues with tenderness to palpation of the cervical and lumbar spine with an antalgic gait as previously described. The succeeding report dated 10/15/2013 notes that there are no changes in the examination. She continues with tenderness to palpation of the paraspinal muscles bilaterally in the cervical spine. There are trigger points with spasms and twitch response with decreased range of motion at the lumbar spine. Her gait is antalgic. The most recent report dated 12/17/2013 documents marked tenderness in the left lumbar paraspinal area with marked tenderness in the right lumbar paraspinal area. Movement is severely restricted

in all directions. Pain elicited in all directions. In this case, the MTUS Guidelines do allow aquatherapy for patients who would cannot tolerate weight bearing exercises. This patient tolerated weight-bearing exercises in the past with plenty of land-based therapy and the treater does not explain why water therapy is needed. Furthermore, the requested 18 aquatic therapy sessions exceeds MTUS recommendations of 8 to 10 visits. The request is not medically necessary and appropriate.

ULTRASOUND LEFT KNEE, WITH POSSIBLE INJECTION (LIDOCAINE): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, Knee & Leg.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) ODG GUIDELINES ON U/S OF THE KNEE, DIAGNOSTIC

Decision rationale: This patient presents with chronic back pain with bilateral lower extremity symptoms. The treater is requesting an ultrasound for the left knee with possible injection. The MTUS and ACOEM Guidelines do not address this request; however, ODG Guidelines on ultrasound for the knee states, "recommended for soft tissue injuries (meniscal, chondral surface injuries, and ligamentous disruption) are best evaluated by MR." Furthermore, it is not generally necessary but may be considered in the following cases: 1. Failure of the initial attempt of the knee joint injection whether provider is unable to aspirate any fluid. 2. The size of the patient's knee due to morbid obesity or disease process, that inhibits the ability to inject the knee without ultrasound guidance. 3. Draining a popliteal cyst. The progress report dated 12/17/2013 documents that there is moderate prepatellar bursa tenderness, moderate anterior medial joint line tenderness, and moderate popliteal fossa tenderness on the left lower extremity. The records show that the patient has not had a previous ultrasound or injection to the left knee. In this case, the treater does not explain why this patient would need an ultrasound with a possible injection, when records do not show that the patient has tried other conservative treatment options for the knee. Furthermore, the patient does not meet the criteria presented by ODG necessary for the procedure requested. The request is not medically necessary and appropriate.