

<b>Case Number:</b>	CM14-0135273		
<b>Date Assigned:</b>	08/29/2014	<b>Date of Injury:</b>	02/28/2011
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	08/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/21/2014

### 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 Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 55 year old male who reported a date of injury of 02/28/2011. The mechanism of injury was not indicated. The injured worker had diagnoses of cervical/lumbar discopathy, carpal tunnel syndrome and double-crush syndrome. Prior treatments included psychotherapy. Prior surgeries were not indicated within the medical records received. The injured worker had complaints of intermittent sharp pain rated 4/10 in the cervical spine that radiated into the upper extremities, and was aggravated by repetitive motions of the neck with associated headaches. The clinical note dated 07/16/2014 noted the injured worker had tenderness to palpation with spasms of the cervical spine, a positive axial loading compression test and a positive Spurling's maneuver. The injured worker had limited range of motion with pain in the cervical spine. The physician indicated there was tenderness to palpation with spasms of the lumbar spine. Range of motion of the lumbar spine was guarded and restricted with standing flexion and extension. Tingling and numbness were present in the injured worker's lateral thigh as well as his anterolateral and posterior leg and foot with L5 and S1 dermatomal patterns. The injured worker had 4/5 strength to his extensor hallucis longus and ankle plantar flexors, asymmetric ankle reflexes and L5 and S1 inverted muscles. Medications were not provided within the medical records received. The plan of treatment included recommendations for physical therapy, referral to a pain management specialist for consideration of lumbar epidural injections, referral to a sleep specialist for a CPAP and, a referral to an internist for hypertension. The rationale and request for authorization form were not provided within the medical records received.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CONSULTATION WITH [REDACTED] FOR LESI: 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 Opioids, criteria for use Page(s): 78.

**Decision rationale:** The injured worker had tenderness to palpation with spasms of the lumbar spine, his range of motion was guarded and restricted with standing flexion and extension. Tingling and numbness were present in the injured worker's lateral thigh as well as his anterolateral and posterior leg and foot with L5 and S1 dermatomal patterns. The California MTUS guidelines recommend consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. The injured worker did have tingling and numbness in his lateral thigh as well as his anterolateral and posterior leg and foot with L5 and S1 dermatomal patterns indicating a possible neurologic deficit. However, there is a lack of documentation indicating the injured worker has failed recent conservative treatments including physical therapy and medications. The request does not specifically indicate [REDACTED] specialty. Without information clarifying [REDACTED] specialty, the medical necessity for a referral to [REDACTED] for a lumbar spine epidural steroid injection is not demonstrated. As such, Consultation with [REDACTED] for LESI is not medically necessary.

**CONSULTATION WITH SLEEP SPECIALIST FOR CPAP: 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) Pain, Office visit.

**Decision rationale:** The injured worker had complaints of intermittent sharp pain of 4/10 in the cervical spine that radiated into the upper extremities. The Official Disability Guidelines note the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. There is a lack of documentation the injured worker had complaints or indications of difficulty sleeping for an extended period of time. There is no indication that the injured worker had excessive daytime somnolence, morning headaches or a sleep related breathing disorder. There is a lack of documentation detailing the prior courses of treatment related to any sleep related breathing disorder. As such, Consultation with Sleep Specialist for CPAP is not medically necessary.

**MODIFIED: CERTIFY SIX (6) PT SESSIONS FOR THE LUMBAR AND CERVICAL SPINE, ORIGINAL SERVICE REQUESTED - PHYSICAL THERAPY FOR LUMBAR AND CERVICAL SPINE; TWO (2) TIMES A WEEK FOR SIX (6) WEEKS:** Upheld

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

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

**Decision rationale:** The injured worker had complaints of intermittent sharp pain of 4/10 in the cervical spine that radiated into the upper extremities, and was aggravated by repetitive motions of the neck with associated headaches. The California MTUS guidelines indicate physical therapy is recommended as active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines recommend 8-10 visits of physical therapy over 4 weeks. The injured worker had limited range of motion with pain in the cervical spine and range of motion of the lumbar spine was guarded and restricted with standing flexion and extension. The injured worker had 4/5 strength in his extensor hallucis longus and ankle plantar flexors. There is a lack of documentation demonstrating the injured worker has significant functional deficits for which physical therapy would be indicated. The requesting physician did not provide a recent, adequate assessment of the injured worker's condition with quantifiable range of motion values. There is a lack of documentation demonstrating whether the injured worker has had prior physical therapy, as well as the efficacy of any prior therapy. As such, Modified: Certify Six (6) Pt Sessions for the Lumbar and Cervical Spine, Original Service Requested - Physical Therapy for Lumbar and Cervical Spine; Two (2) Times a Week for Six (6) Weeks is not medically necessary.