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| Case Number: | CM14-0163510 | | |
| Date Assigned: | 10/08/2014 | Date of Injury: | 12/14/2000 |
| Decision Date: | 12/08/2014 | UR Denial Date: | 09/08/2014 |
| Priority: | Standard | Application Received: | 10/06/2014 |

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 Orthopedic Surgery and is licensed to practice in Alabama. 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 60-year-old male who reported injury on 12/14/2000. The mechanism of injury was a motor vehicle accident. Prior therapies for the knee and ankle included physical therapy. The injured worker's medications included Aciphex and Norco 10/325 mg. The injured worker underwent a right shoulder arthroscopy with subacromial decompression and debridement of the rotator cuff, as well as an arthroscopic distal clavicle excision on 05/06/2010, and underwent a left shoulder arthroscopic debridement of a superior labral tear, distal clavicle excision and subacromial decompression on 04/10/2013 and a left knee total arthroplasty on 12/30/2013. The injured worker underwent an ACDF with anterior plate and screw fixation with a date not provided. The injured worker underwent x-rays of the left knee on 07/24/2014 which revealed a well-positioned total knee replacement. The injured worker was noted to undergo an MRI of the lumbar spine. The injured worker underwent an MRI of the cervical spine without contrast on 06/20/2011 which revealed at the level of C4-5 there was a concentric uncovertebral hypertrophy 1 mm which in conjunction with facet hypertrophy and ligamentum flavum laxity produced mild central canal narrowing and moderate bilateral neural foraminal narrowing. At the level of C6-7 there was concentric uncovertebral hypertrophy in conjunction with facet hypertrophy and ligamentum flavum laxity producing mild central canal narrowing and moderate bilateral neural foraminal narrowing. The documentation of 06/04/2014 revealed the injured worker had pain in the left side of the neck radiating into the left shoulder blade, right side of the low back and left sided hip pain. The duration of lasting effects was 1 and a half years. The documentation further indicated the injured worker had an arthroscopy in the right ankle in 2012 and arthroscopy to the left shoulder in 2013. The injured worker had 8 sessions of home physical therapy and 16 sessions of outpatient physical therapy for the left total knee arthroplasty that was performed on 12/30/2013. The physical examination of the cervical spine revealed

decreased range of motion. There was no motor deficit or atrophy. There was no hypoesthesia to light touch in the biceps and triceps reflexes were symmetrical. The injured worker had decreased range of motion of the lumbar spine. There was no tenderness in the sciatic notch bilaterally. There was hamstring tightness. There was no motor deficit or atrophy. The knee and ankle reflexes were symmetrical bilaterally and sensation was intact to light touch. There was swelling in the right paraspinal muscle in the upper back. The diagnoses included degenerative intervertebral disc in the cervical and lumbar region, rupture tendon non-traumatic rotator cuff, and osteoarthritis localized primarily ankle and foot and joint knee prosthesis. The assessment included a recommendation for epidural steroid injection followed by physical therapy. The recommendation was for an MRI to evaluate the herniated disc followed by physical therapy in the low back. Additionally, the recommendation was for the left knee 8 more sessions of physical therapy to improve range of motion. The physician documented he would like to get an MRI of the neck to see if the neck was getting worse. There was a Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural Steroid Injection (bilateral C4-5): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection Page(s): 46 of 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: The California Medical Treatment & Utilization Schedule Guidelines recommend for repeat epidural steroid injection there should be documentation of at least 50% to 70% relief to 6 to 8 weeks and documentation of an objective decrease in pain medications and an objective improvement in function. The clinical documentation submitted for review failed to meet the above criteria. The documentation indicated the injured worker had relief for 1 and a half years. However, there was a lack of documentation indicating the objective relief in pain. As such, the request for epidural steroid injection (bilateral C4-5) is not medically necessary.

Epidural Steroid Injection (bilateral C7-8): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection Page(s): 46 of 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend for repeat epidural steroid injection there should be documentation of at least 50% to 70% relief to 6 to 8 weeks and documentation of an objective decrease in pain medications and an objective improvement in function. The clinical documentation submitted for review failed to

meet the above criteria. The documentation indicated the injured worker had relief for 1 and a half years. However, there was a lack of documentation indicating the objective relief in pain. As such, the request for epidural steroid injection (bilateral C7-8) is not medically necessary.

Physical Therapy (6-sessions, for the left knee for osteoarthritis): 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 California Medical Treatment Utilization Schedule Guidelines recommend physical medicine for up to 10 sessions for myalgia and myositis. The clinical documentation submitted for review indicated the injured worker had previously undergone physical therapy. There was a lack of documentation to indicate the objective functional benefit that was received from the prior therapy. There was a lack of documentation indicating that the injured worker had objective functional deficits to support the necessity for further supervised therapy. Given the above, the request for physical therapy (6-sessions, for the left knee for osteoarthritis) is not medically necessary.

Physical Therapy (5-sessions, for the left ankle for osteoarthritis): 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 California Medical Treatment Utilization Schedule Guidelines recommend physical medicine for up to 10 sessions for myalgia and myositis. The clinical documentation submitted for review indicated the injured worker had previously undergone physical therapy. There was a lack of documentation to indicate the objective functional benefit that was received from the prior therapy. There was a lack of documentation indicating that the injured worker had objective functional deficits to support the necessity for further supervised therapy. Given the above, the request for physical therapy (5-sessions, for the left ankle for osteoarthritis) is not medically necessary.

Post-Op Physical Therapy (5-sessions, for the left knee for loss of function): Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Decision rationale: The California Medical Treatment Utilization Schedule Postsurgical Treatment Guidelines were not applied as the injured worker was passed the postsurgical treatment timeframe. The California Medical Treatment Utilization Schedule Guidelines recommend physical medicine for up to 10 sessions for myalgia and myositis. The clinical documentation submitted for review indicated the injured worker had previously undergone physical therapy. There was a lack of documentation to indicate the objective functional benefit that was received from the prior therapy. There was a lack of documentation indicating that the injured worker had objective functional deficits to support the necessity for further supervised therapy. Given the above, the request for post-op physical therapy (5-sessions, for the left knee for loss of function) is not medically necessary.