

Case Number:	CM14-0175209		
Date Assigned:	10/28/2014	Date of Injury:	05/31/2008
Decision Date:	12/12/2014	UR Denial Date:	10/10/2014
Priority:	Standard	Application Received:	10/23/2014

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 Internal Medicine, has a subspecialty in Nephrology 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 50 year-old female with a 5/31/08 date of injury. Mechanism of injury was cumulative trauma from repetitive phone use, due to habitual cradling of the phone receiver between her neck and right shoulder. She received physical therapy and acupuncture 5 years ago, with mild symptomatic relief. A cervical MRI dated 2/15/06 showed disc herniations at C5-6 and C6-7. There is no mention of abnormal findings at the C7-T1 level. The patient was most recently seen on 10/2/14 with complaints of neck pain, rated as 8/10, with radiation down the right arm. Pain had been worsening since her injury 5 years ago. According to the treatment note, the patient had not yet begun taking prescribed medications, due to authorization delays. Exam findings revealed reduced range of motion in the cervical spine, due to pain. Upon palpation of the cervical paraspinal muscles, there was tenderness and trigger point activity on the right side. Spurling's test caused neck pain, with radiation down the right arm. Neurological examination revealed motor strength to be reduced (4/5) at the right elbow flexor. Remaining muscle groups of the right upper extremity are minimally reduced (5-/5), with the exception of the wrist flexor, which was normal (5/5). Wadell's signs were negative. The patient's diagnoses included: 1) Cervical radiculopathy. 2) Cervical spondylosis. The medications included Ultracet, Zorvolex, Tylenol E.S. Significant Diagnostic Tests: MRI. Treatment to date: medications. An adverse determination was received on 10/10/14 due to ODG guideline recommendations for initial therapy to include physical medicine with a cognitive motivational approach. Although the patient underwent physical therapy 5 years ago, there was no mention in the medical records of a cognitive motivational approach having been utilized. Regarding the epidural injection, there was an absence of physical findings specific to a dermatome distribution, and no correlative MRI findings suggestive of neuroforaminal encroachment on the right side of the requested

vertebrae. Moreover, medications had not been utilized, and the last physical therapy attempt was 5 years ago.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 pain management evaluation for cognitive behavioral therapy and pain-coping skills training: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Cognitive Behavioral Therapy (CBT) guidelines for chronic pain: Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), cognitive behavioral therapy (CBT) guidelines for back problems

Decision rationale: ODG cognitive behavioral therapy (CBT) guidelines for back problems: Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these at risk patients should be physical therapy exercise instruction, using a cognitive motivational approach to PT. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone: - Initial trial of 3-4 psychotherapy visits over 2 weeks- With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions)- Psychotherapy visits are generally separate from physical therapy visits, and psychotherapy may be appropriate after physical therapy has been exhausted. This patient is being treated for a cumulative trauma neck injury that occurred 5 years ago. At the time of the injury, she underwent physical therapy and acupuncture, with mild relief reported. ODG guidelines recommend that cognitive behavioral therapy be preceded by physical therapy instruction using a cognitive motivational approach. Separate psychotherapy CBT is to be considered if there is a lack of progress following 4 weeks of physical therapy alone. However, there is no evidence in the medical record that the patient's physical therapy program 5 years ago utilized such a cognitive motivational approach. Therefore, the request for pain management evaluation for cognitive behavioral therapy and pain-coping skills training is not medically necessary.

Cervical epidural injection C7-T1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Regarding Epidural steroid injections (ESIs) Criteria for the use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation AMA Guides (Radiculopathy)

Decision rationale: CA MTUS supports epidural steroid injections in patients with radicular pain that has been unresponsive to initial conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In addition, no more than two nerve root levels should be injected using transforaminal blocks, and no more than one interlaminar level should be injected at one session. Furthermore, CA MTUS states that repeat blocks should only be offered if at least 50% pain relief with associated reduction of medication use for six to eight weeks was observed following previous injection. This patient has been under care for a cumulative trauma neck injury that occurred 5 years ago. Current complaints included 8/10 neck pain that radiates down the right arm. Physical exam revealed localized cervical paraspinal muscle tenderness, and trigger point activity. On neurological exam, there was minimal weakness due to pain in a diffuse dermatomal distribution in the affected right upper extremity. A 2006 MRI showed degenerative disc disease at 2 spinal levels, but did not include mention of neuroforaminal narrowing or nerve root compression at vertebral level C7-T1. This patient does have complaints of radicular pain, involving the neck and right arm. However, physical exam fails to localize pathology to the proposed C7-T1 dermatomal distribution, and there is no correlative support on imaging studies, for C7-T1 nerve compression. Moreover, conservative measures, such as medication and physical therapy, have not yet been attempted. Therefore, the request for cervical epidural injection C7-T1 is not medically necessary.