

Case Number:	CM14-0067953		
Date Assigned:	08/06/2014	Date of Injury:	08/27/2010
Decision Date:	09/10/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/12/2014

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 Family Medicine 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 61 year old female who reported an industria linjury on 8/27/2010; over four (4) years ago, to the neck back and shoulder attributed to the performance of her customary job tasks. The patient was reported to be working full duty at the present time. The patient complained of numbness to the left hand and left foot along with left-sided neck pain. Patient reported lower back pain radiating down to the left lower extremity associated with numbness and tingling to the left leg. The patient was noted to have previously obtained chiropractic care with some improvement. Patient has also received prior physical therapy. It was reported that the patient requested to attempt physical therapy again. It was as noted that the patient did not wish to have a lumbar spine epidural steroid injection. The objective findings on examination included decreased range of motion to the cervical spine; tenderness on the left upper arm on biceps and triceps; DTRs symmetrical; range of motion of the shoulders decreased left worse than right; tenderness to the left epicondyle medial lateral; wrist and hands with decreased sensation on fingers on left along Moeller and dorsal aspect; Phalen's test positive; positive Tinel's sign on left; lumbar paravertebral muscles severely spastic bilaterally worse on the left; decreased range of motion to the lumbar spine; decreased sensation on left L4, L5, and S1 levels; tenderness to the left trochanteric bursal area. A prior electrodiagnostic study documented evidence of left-sided S1 radiculopathy. The Electrodiagnostic study of the bilateral upper extremities documented evidence of possible left medial, left ulnar, and left radial neuropathy. The patient was noted to have an MRI of the cervical spine during 3/211 which showed very early degenerative changes of the cervical spine without spinal canal or foraminal narrowing. The treating diagnoses included lumbar strain/sprain; cervical spine strain/sprain; left shoulder strain; myofascial syndrome; brachial plexus Fathi; left shoulder pain; cervical radiculitis C6 left;

lumbosacral radiculitis left S1; left trochanteric bursitis; dyspepsia due to NSAID; epicondylitis left medial and lateral.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI CS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG, Neck and Upper Back (Last Updated 4/14/14).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182,177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back MRI.

Decision rationale: The request for a MRI of the cervical spine was not supported with objective findings on examination to support medical necessity. The patient is four years s/p DOI and has had a prior cervical spine MRI with minimal DJD. The rationale for the requested imaging studies was not documented and there was no objective evidence to support the medical necessity of the requested imaging studies. The patient was not documented to have been provided conservative treatment and was not documented to have failed the attempted conservative treatment. The criteria recommended by evidence based guidelines were not documented to support the medical necessity of the requests. There is no rationale provided by the requesting provider to support the medical necessity of a repeated MRI of the cervical spine as a screening study. There are no demonstrated red flag diagnoses as recommended by the ACOEM Guidelines in order to establish the criteria recommended for a MRI of the cervical spine. The medical necessity of the requested MRI of the cervical spine was not supported with the subjective/objective findings recommend by the ACOEM Guidelines or the Official Disability Guidelines for the authorization of a cervical spine MRI. The patient's treatment plan did not demonstrate an impending surgical intervention or any red flag diagnoses. The treatment plan was not demonstrated to be influenced by the obtaining of the Cervical MRI. There were no demonstrated sensory or motor neurological deficits on physical examination; there were no demonstrated changes to the patient's neurological examination other than the subjective pain complaint; and the patient was not shown to have failed a conservative program of strengthening and conditioning. The patient is not documented as contemplating surgical intervention to the cervical spine. There were no documented clinical changes in the patient's clinical status or documented motor/sensory neurological deficits that would warrant the authorization of a MRI of the cervical spine/thoracic spine or meet the recommendations of the currently accepted evidence based guidelines. There is no provided rationale for the MRI of the cervical spine/thoracic spine by the requesting provider. The MRI results were not noted to affect the course of the recommended conservative treatment. The functional assessment for the provided conservative therapy since the date of injury has not been documented or provided in the physical therapy documentation. There was no demonstrated medical necessity for a repeated MRI of the cervical spine.

MRI TS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG, Neck and Upper Back (Last Updated 4/14/14).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182,177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back.

Decision rationale: The request for authorization of a thoracic spine MRI was not supported with objective findings on examination to support medical necessity. The rationale for the requested imaging studies was not documented and there was no objective evidence to support the medical necessity of the requested imaging studies. The patient was not documented to have been provided conservative treatment and was not documented to have failed the attempted conservative treatment. The criteria recommended by evidence based guidelines were not documented to support the medical necessity of the requests. There is no rationale provided by the requesting provider to support the medical necessity of the MRI of the thoracic spine four years after the date of injury. There are no demonstrated red flag diagnoses as recommended by the ACOEM Guidelines in order to establish the criteria recommended for a MRI of the thoracic spine. The medical necessity of the requested MRI of the thoracic spine was not supported with the subjective/objective findings recommend by the ACOEM Guidelines or the Official Disability Guidelines for the authorization of a thoracic MRI. The patient's treatment plan did not demonstrate an impending surgical intervention or any red flag diagnoses. The treatment plan was not demonstrated to be influenced by the obtaining of the Thoracic MRI. There were no demonstrated sensory or motor neurological deficits on physical examination; there were no demonstrated changes to the patient's neurological examination other than the subjective pain complaint; and the patient was not shown to have failed a conservative program of strengthening and conditioning. The patient is not documented as contemplating surgical intervention to the thoracic spine. There were no documented clinical changes in the patient's clinical status or documented motor/sensory neurological deficits that would warrant the authorization of a MRI of the thoracic spine or meet the recommendations of the currently accepted evidence based guidelines. There is no provided rationale for the MRI of the thoracic spine by the requesting provider. The MRI results were not noted to affect the course of the recommended conservative treatment. The functional assessment for the provided conservative therapy since the date of injury has not been documented or provided in the physical therapy documentation. The MRI of the thoracic spine is not demonstrated to be medically necessary.

MRI LS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation (ODG), (TWC) Official Disability Guidelines, Treatment in Workers' Compensation: Low Back Procedure Summary Last Updated 3/31/14.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-04,52. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter MRI.

Decision rationale: The request for authorization of the MRI of the lumbar spine is not supported with objective evidence that demonstrates medical necessity or meets the criteria recommended by evidence based guidelines for the date of injury over four years ago. There is no rationale or documented objective findings to support the medical necessity of a lumbar spine MRI provided by the requesting provider to support the medical necessity of the MRI of the lumbar spine. There are no demonstrated red flag diagnoses as recommended by the ACOEM Guidelines in order to establish the criteria recommended for MRI studies lumbar spine. The medical necessity of the requested MRI of the lumbar spine was not supported with the subjective/objective findings recommend by the ACOEM Guidelines or the Official Disability Guidelines for the authorization of a lumbar MRI. The patient's treatment plan as stated by Dr. Fonseca did not demonstrate an impending surgical intervention or any red flag diagnoses. The treatment plan was not demonstrated to be influenced by the obtaining of the lumbar MRI of the lumbar spine. There were no demonstrated sensory or motor neurological deficits on physical examination; there were no demonstrated changes to the patient's neurological examination other than the subjective pain complaint; the palpable musculoskeletal tenderness, and the patient was not shown to have failed a conservative program of strengthening and conditioning. The patient is not documented as contemplating surgical intervention to the lumbar spine. There were no documented clinical changes in the patient's clinical status or documented motor/sensory neurological deficits that would warrant the authorization of a MRI of the lumbar spine or meet the recommendations of the currently accepted evidence based guidelines. There is no provided rationale for the MRI of the lumbar spine by the requesting provider. The MRI results were not noted to affect the course of the recommended conservative treatment. The functional assessment for the provided conservative therapy since the date of injury has not been documented or provided in the physical therapy documentation. There is no demonstrated medical necessity for the MRI of the lumbar spine.

Physical Therapy x12, CS, TS, LS and Left Shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back section PT; back section PT; shoulder section PT.

Decision rationale: There was no evidence that the patient could not perform strengthening and conditioning exercises in a self-directed home exercise program. There were no objective that supported the medical necessity of additional PT over the recommendations of the CA MTUS or over the recommended self directed home exercise program for the lumbar spine, cervical spine, thoracic spine and left shoulder. The patient is not documented to have weakness and muscle atrophy. The patient is documented only to have TTP and diminished ROM. The patient received substantial prior PT and chiropractic care. The patient has received ongoing sessions of PT for

the industrial injury and has exceeded the number of sessions and time period for rehabilitation recommended by the CA MTUS. The CA MTUS recommends nine to ten (9-10) sessions of physical therapy over 8 weeks for the lumbar/cervical spine for sprain/strains, degenerative disc disease or lumbar radiculopathies. The CA MTUS recommends up to ten (10) sessions of physical therapy over eight (8) weeks for the rehabilitation of the shoulder subsequent to the diagnosis of sprain/strain or impingement. The patient has exceeded the recommendations of the CA MTUS for treatment of the left shoulder, neck, and lower back. The patient has received prior sessions of physical therapy directed to the left shoulder, cervical spine, thoracic spine, and lumbar spine and should be in a HEP. The subsequent conditioning and strengthening is expected to be accomplished with the self-directed home exercise program. There is no objective evidence provided to support the medical necessity of additional PT over the number recommended by the CA MTUS. The requested twelve (12) sessions of additional PT represents maintenance care and is not demonstrated to be medically necessary.

Lumbar Epidural Steroid Injection (LESI): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LESI Lumbar Epidural Steroid Injection (ESI) Steroid Injection.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,179-80,Chronic Pain Treatment Guidelines Epidural Steroid injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Back chapter--lumbar spine ESI.

Decision rationale: The criteria recommended by the CA MTUS for the provision of lumbar ESIs were not documented. The patient does meet the CA MTUS criteria for a lumbar ESI under fluoroscopic guidance to an unspecified lumbar spine level. The use of lumbar spine ESIs is recommended for the treatment of acute or subacute radicular pain in order to avoid surgical intervention. The patient is not noted to have objective findings on examination consistent with a bilateral nerve impingement radiculopathy. The reported radiculopathy was not corroborated by imaging studies or Electrodiagnostic studies as acute. There is no demonstrated nerve impingement radiculopathy on the MRI. There is no impending surgical intervention. The patient is being treated for chronic low back pain with radiation to the lower extremities. The request for lumbar ESI is directed to degenerative disc disease without evidence of an acute nerve impingement radiculopathy. Evidence based guidelines recommend the provision of one ESI with a subsequent evaluation for functional improvement prior to authorization of a second lumbar spine ESI. There is no documented rehabilitation effort. The stated diagnoses and clinical findings do not meet the criteria recommended by evidence based guidelines for the use of a lumbar ESI by pain management. The CA MTUS requires that "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or Electrodiagnostic testing." The ACOEM Guidelines updated Back Chapter revised 8/08/08 does not recommend the use of lumbar ESIs for chronic lower back pain. The Official Disability Guidelines recommend that ESIs are utilized only in defined radiculopathies and a maximum of two lumbar diagnostic ESIs and a limited number of therapeutic lumbar ESIs are recommended in order for the patient to take advantage of the window of relief to establish an appropriate self-directed home exercise program for conditioning and strengthening. The criteria for a second

diagnostic ESI is that the claimant obtain at least 50% relief from the prior appropriately placed ESI. The therapeutic lumbar ESIs are only recommended "if the patient obtains 50-70% pain relief for at least 6-8 weeks." Additional blocks may be required; however, the consensus recommendation is for no more than 4 blocks per region per year. The indications for repeat blocks include "acute exacerbations of pain or new onset of symptoms." Lumbar ESIs should be performed at no more than two levels at a session. Although epidural injection of steroids may afford short-term improvement in the pain and sensory deficits in patients with radiculopathy due to herniated nucleus pulposus, this treatment, per the guidelines, seems to offer no significant long-term functional benefit, and the number of injections should be limited to two, and only as an option for short term relief of radicular pain after failure of conservative treatment and as a means of avoiding surgery and facilitating return to activity. There is no demonstrated medical necessity for lumbar spine ESI for the reported chronic back pain issues.