

Case Number:	CM14-0077197		
Date Assigned:	07/18/2014	Date of Injury:	08/31/1998
Decision Date:	09/24/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	05/27/2014

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 and is licensed to practice in Maryland. 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 employee was a 50 year old female who was status post work related injury on 08/31/1998 when she had a syncopal episode and a fall with neck and back injury. Her complaints were neck pain radiating to bilateral upper extremities and bilateral shoulder pain. Her diagnoses included lumbar and cervical radiculopathy. Her past medical history included depression, diabetes mellitus, hypertension, dyspepsia and anxiety. She had chronic cervical spine pain syndrome with multilevel degenerative disc disease, past history of anterior cervical discectomy with artificial disc prosthesis at C3-C4 interspace in 2008, removal of instrumentation, exploration of fusion at C4-C5 and C5-C6 with revision decompression and fusion, anterior cervical discectomy and interbody fusion at C6-C7 interspace with anterior spinal instrumentation in 2012. She was status post bilateral shoulder arthroscopic subacromial decompressions. Her prior evaluations included an MRI of lumbar spine in April 2012 that showed 2mm midline disc protrusion with mild effacement of thecal sac at L5-S1, mild facet arthropathy of the lower lumbar spine and a CT scan of the cervical spine in June 2012 showed multilevel spinal neural foraminal stenosis involving C5-C6 and C6-C7. EMG/NCV on 07/27/12 of bilateral upper and lower extremities showed mild chronic neuropathic changes in bilateral L4-L5 distribution and bilateral C5-C6 distribution as well as mild carpal tunnel syndrome. She was seen by the pain management provider on 05/07/14. She had neck pain radiating down both upper extremities. She had low back pain radiating down both lower extremities. She had ongoing headaches and jaw pain. Pain was 8-9/10 in intensity without medications and 6/10 with medications. Areas of functional improvement include bathing, concentrating, dressing, driving, less medication needed and mood. Pertinent examination findings include 18/18 tender points, spasm noted in paraspinous muscles of C spine, spinal vertebral tenderness in C4-C7, limited range of motion and tenderness with limited range of motion of paravertebral muscles of lumbar spine. The

diagnoses included cervical and lumbar radiculopathy, fibromyalgia, headaches, anxiety, depression, hypertension, insomnia and chronic pain. Medications included Halcion, Xanax, MS Contin, Lexapro, Neurontin, Soma, Lidoderm patch, Percocet, Provigil, Lotensin, Motrin, Ritalin, Prilosec, Keflex and Promethazine. X-ray of the cervical spine on 01/15/14 noted seven cervical vertebrae in good alignment, no hardware loosening and no compression fracture or listhesis. An MRI of lumbar spine done on 03/17/14 revealed 2-3mm broad based right paracentral disc protrusion at the L5-S1 level compressing the traversing right S1 nerve root with no frank disc herniations or extrusions. For future medical care, she was encouraged to walk, stationary cycle, perform yoga and water aerobic type exercises. She was asked to use a low, flat or cervical pillow while sleeping. Ambulatory assistive devices were not indicated. She was seen by the treating provider on 03/06/14. She continued to report pain in the neck radiating to bilateral upper extremities with numbness and tingling. She had bilateral shoulder pain, low back pain radiating to legs, sleep deprivation, stress, anxiety and depression, stomach pain and dental decay. She had spasm of paravertebral muscles of cervical and lumbar spine, limited range of motion of spine and positive straight leg raising test. Her diagnoses included postop cervical spine fusion, lumbar spine HNP, sleep deprivation, hypertension, stress, anxiety and depression, gastritis and dental decay. The plan of care included gym membership for aqua therapy three times a week for six weeks, MRI of lumbar spine for the upcoming epidural and followup with Neurology and Spine surgery consultants. She was seen by Rheumatology and was diagnosed with fibromyalgia. Recommendations included aqua therapy. She had been scheduled for an epidural steroid injection of her cervical spine. She was having ongoing neurological deficits and needed followup with Neurology. Her other symptoms included ongoing urinary incontinence and inability to drive.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow up visits with [REDACTED] and [REDACTED]: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 1. Decision based on Non-MTUS Citation (ACOEM), 2nd Edition, (2004) Surgery referral, Page 305-306.

Decision rationale: The employee was being treated for multiple diagnoses including cervical and lumbar radiculopathy, chronic pain, fibromyalgia, migraines, headaches, status post cervical fusion, stress and depression. Her management so far has included, care by multiple providers, opioid analgesics, Halcion, Lexapro, Neurontin, Lidoderm patch, cervical fusion, revision of cervical surgery, physical therapy and home exercise program. She was noted to have ongoing headaches in several visit notes. ACOEM guidelines indicate that a referral for surgical consultation is indicated for patients with severe and disabling lower leg symptoms with objective signs and progression of symptoms despite conservative management. MTUS Chronic Pain Medical Treatment guidelines indicate that a persistent complaint should lead a primary treating provider to reconsider the diagnosis and decide whether a specialist consultation is necessary. In this case, the employee had multiple ongoing symptoms. She had been evaluated

by various specialists and was on multiple medications. Despite the above care, she continued to have disabling radicular symptoms as well as headaches. Her radicular symptoms had failed to improve despite having medications, home exercise program and also epidural injections. Hence the request for followup with Neurology and Spine surgery is necessary and appropriate.

Physical Therapy 2 times a week for 4 weeks: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Neck and upper back, Physical therapy.

Decision rationale: The employee was being treated for multiple diagnoses including cervical and lumbar radiculopathy, chronic pain, fibromyalgia, migraines, headaches, status post cervical fusion, stress and depression. Her management so far has included, care by multiple providers, opioid analgesics, Halcion, Lexapro, Neurontin, Lidoderm patch, cervical fusion, revision of cervical surgery, physical therapy and home exercise program. According to Official Disability Guidelines, upto 12 physical therapy visits over 10 weeks is recommended for cervical radiculitis. Thorough review of records showed no physical therapy notes or evidence that she had received physical therapy recently. Hence the request for physical therapy 2 visits for 4 weeks is medically necessary and appropriate.

Gym Membership times 6 months for Aquatic Therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22. Decision based on Non-MTUS Citation (ODG) Low back, lumbar and thoracic, Gym memberships.

Decision rationale: The employee was being treated for multiple diagnoses including cervical and lumbar radiculopathy, chronic pain, fibromyalgia, migraines, headaches, status post cervical fusion, stress and depression. Her management so far has included, care by multiple providers, opioid analgesics, Halcion, Lexapro, Neurontin, Lidoderm patch, cervical fusion, revision of cervical surgery, physical therapy and home exercise program. According to Official Disability Guidelines, a gym membership is not recommended unless a home exercise program has not been effective and there is a need for specialized equipment. Plus, treatment needs to be monitored and administered by medical professionals. Gym memberships and unsupervised programs provide no information flow back to the provider, so they can make changes to the prescription and there may be a risk for further injury to the patient. Gym memberships, swimming pools etc would not generally be considered medical treatment, and are therefore not recommended. Hence the request for gym membership for 6 months with aquatic therapy is not medically necessary or appropriate.

Magnetic Resonance Imaging, L Spine with flexion and extension films: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Low back, lumbar and thoracic, MRIs.

Decision rationale: The employee was being treated for multiple diagnoses including cervical and lumbar radiculopathy, chronic pain, fibromyalgia, migraines, headaches, status post cervical fusion, stress and depression. Her management so far has included, care by multiple providers, opioid analgesics, Halcion, Lexapro, Neurontin, Lidoderm patch, cervical fusion, revision of cervical surgery, physical therapy and home exercise program. Her prior evaluations included an MRI of lumbar spine in April 2012 that showed 2mm midline disc protrusion with mild effacement of thecal sac at L5-S1, mild facet arthropathy of the lower lumbar spine and a CT scan of the cervical spine in June 2012 showed multilevel spinal neural foraminal stenosis involving C5-C6 and C6-C7. EMG/NCV on 07/27/12 of bilateral upper and lower extremities showed mild chronic neuropathic changes in bilateral L4-L5 distribution and bilateral C5-C6 distribution as well as mild carpal tunnel syndrome. According to Official Disability Guidelines, corroboration with imaging and electrodiagnostic studies is recommended prior to ESIs. But repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology like tumor, infection, fracture, neurocompression or recurrent disc herniation. A previous MRI done showed disc protrusion and a prior EMG/NCV showed mild neuropathic changes in L4-5 distribution. There is also report that she had prior ESI with improvement. The notes don't enumerate exceptional factors that necessitate a repeat MRI of lumbar spine. Hence the request for MRI of lumbar spine is not medically necessary or appropriate.