

Case Number:	CM15-0012856		
Date Assigned:	01/27/2015	Date of Injury:	07/21/2011
Decision Date:	04/08/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	01/22/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Internal Medicine

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 59 year old male, who sustained an industrial injury on July 21, 2011. The diagnoses have included lumbar sprain, lumbar radiculopathy, sacroiliac joint dysfunction, chronic pain, lumbar facet arthritis, a thoracic sprain and major depressive disorder. Treatment to date has included medications, MRI, x-rays, psychological examination and pulmonary consultation. Current documentation dated July 28, 2014 notes that the injured worker complained of pain throughout his body, especially in the back and side, headaches, muscle weakness, anxiety, depression and coughing. He remains worried about his physical disabilities, physical movement and activity. Utilization Review references documentation dated December 15, 2014, which was not submitted for this review. On January 8, 2015 Utilization Review non-certified a request for physical therapy three times a week for four weeks to the lumbar and cervical spine and a cervical epidural steroid injection to the cervical six-cervical seven level. The MTUS, Chronic Pain Medical Treatment Guidelines, were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3x4 lumbar/ cervical spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine Pages 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Physical medicine treatment. Official Disability Guidelines (ODG) Preface, Physical Therapy Guidelines.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Per Medical Treatment Utilization Schedule (MTUS) definitions, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions, and a reduction in the dependency on continued medical treatment. Official Disability Guidelines (ODG) present physical therapy PT guidelines. Patients should be formally assessed after a six visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. The primary treating physician's progress report dated 7/28/14 addressed psychiatric complaints. The pulmonary office visit reports dated 9/24/14 and 1/20/15 addressed respiratory complaints. No physical examination of the spine was documented in the submitted medical records. No functional improvement with past physical therapy was documented. Twelve sessions of PT physical therapy for the lumbar and cervical spine were requested. Per ODG, patients should be formally assessed after a six visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. The request for 12 physical therapy PT visits exceeds MTUS and ODG guidelines, and is not supported. Therefore, the request for physical therapy is not medically necessary.

Cervical epidural steroid injection C6-7: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175, 181-183, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page 46.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses epidural steroid injection (ESI). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints states that cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. Medical treatment utilization schedule (MTUS) Chronic Pain Medical Treatment Guidelines (Page 46) states that epidural steroid injections (ESI) are an option for radicular pain (defined as pain in

dermatomal distribution with corroborative findings of radiculopathy). The American Academy of Neurology recently concluded that there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. ESI treatment alone offers no significant long-term functional benefit. Criteria for the use of epidural steroid injections requires that radiculopathy must be documented by physical examination and corroborated by imaging studies or electrodiagnostic testing. The primary treating physician's progress report dated 7/28/14 addressed psychiatric complaints. The pulmonary office visit reports dated 9/24/14 and 1/20/15 addressed respiratory complaints. No physical examination of the spine was documented in the submitted medical records. The MTUS criteria for the use of epidural steroid injections requires that radiculopathy must be documented by physical examination and corroborated by imaging studies or electrodiagnostic testing. No physical examination findings of radiculopathy were noted. No imaging studies or electrodiagnostic testing results were documented. The medical records do not provide support for the request for cervical epidural steroid injection. Therefore, the request for cervical epidural steroid injection is not medically necessary.