

<b>Case Number:</b>	CM15-0137197		
<b>Date Assigned:</b>	07/27/2015	<b>Date of Injury:</b>	10/14/2012
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	06/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2015

### 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, Massachusetts

Certification(s)/Specialty: Preventive Medicine, Occupational 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 55-year-old female, who sustained an industrial injury on 10-14-2012. According to 4/14/15 clinic note with treating provider the IW has lower back pain with bilateral lower extremity symptoms rated 6/10, cervical pain and right shoulder pain also 6/10 VAS. There are no reported side effects. On exam, there is cervical and lumbar spinal tenderness with decreased range of motion. Sensation is diminished along L5 and S1 dermatomes. On most recent provider visit dated 05/06/2015 the injured worker has reported neck pain and lower back pain, which is rated as 8/10 both with and without medications. Side effects include constipation and dizziness. UDS is negative for all tested substances. On examination of the lumbar spine range of motion was decreased and tenderness to palpation over the bilateral SI joint. Cervical spine range of motion was noted to be decreased and tenderness was noted over the cervical spine reproducing headaches. The diagnoses have included lumbosacral spondylosis without myelopathy. Treatment to date has included medication including lyrica, nortriptyline, imitrex, ibuprofen, and Tramadol 50mg every 8 hours as needed for pain. The provider requested bilateral lumbar level 3,4, and 5 medial branch block #2, acupuncture right shoulder, physical therapy for core strengthening , positioning, manual therapy, modalities and home exercise program #12, urine drug screen and aqua therapy #12. There is no mention in the records provided if PT or aqua therapy has been attempted before and if so whether there was any clinically benefit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Lumbar level 3, 4 and 5 Medial Branch Block #2: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lower back/ Criteria for use of diagnostic blocks for facet mediated pain.

**Decision rationale:** According to ODG, medial branch blocks may be appropriate once fact pathology has been established by both physical exam findings and symptomatology, such as absence of radicular findings and normal sensory examination. The IW has decreased sensation at L5 and S1 dermatomes indicating that the facet joint may not be the origin of pain symptoms. Addition guideline criteria include "limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally". The injured worker has radicular symptoms and it is present at more than 2 levels. Additionally it is recommended, "No more than 2 facet joint levels are injected in one sessions" while the current request is for three levels. Based on the cited guidelines and the clinical records provided, this intervention is not medically necessary at this time.

**Acupuncture Right shoulder, no frequency/duration stated: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** Acupuncture is a clinical modality that is effective in select patients with musculoskeletal injuries and chronic pain. However, acupuncture should be started under a clear treatment plan and protocol with set frequency, duration and treatment goals set out prior to initiating treatment. Based on the lack of document ion on planned frequency, duration and treatment goals, the current request is not medically necessary or appropriate at this time.

**Physical Therapy for core strengthening, positioning, manual therapy, modalities and HEP, quantity 12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-101.

**Decision rationale:** According to MTUS guidelines physical therapy is recommended, as it is helpful in "controlling symptoms such as pain, inflammation and swelling to improve the rate of healing of soft tissue injuries". The MTUS guidelines allow for an initial course of up to 9-10 PT visits over 8 weeks. Consequently based on the guidelines and my review of the provided records I believe the requested sessions of physical therapy are NOT indicated at this time as the IW has already had prior courses of PT and there is no documentation that prior courses were effective and that a renewal of physical therapy is not medically necessary at this time.

**Retrospective urine drug screen DOS 5-6-15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Testing Page(s): 43.

**Decision rationale:** Urine drug testing is indicated when the patient is taking a substance such as opioids that requires regular screening for illicit substances that could put the IW at risk for adverse drug reactions. The IW is prescribed Tramadol; however, UDS reviewed was negative for this medication indicating that the IW is not actively taking the medication. As such, routine and regular screening for illegal substances is not medically necessary. As well, the IW is not noted to be a high-risk patient for abuse, therefore regular UDS is not medically necessary.

**Aqua therapy quantity 12:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aqua therapy Page(s): 22.

**Decision rationale:** Aqua therapy is indicated as an alternative for land base therapy when there is a specific diagnosis or impairment that can benefit from low intensity therapy that cannot otherwise be obtained by land-based therapy. In the clinic records reviewed, there is no discussion of specific impairment, disability or diagnosis that would suggest aqua therapy is necessary. Additionally, previous physical medicine interventions such as PT were not successful, and there is no indication from the clinic records provided to suggest that aqua therapy would be more efficacious. This request is not medically necessary.