Case Number:	CM15-0194259		
Date Assigned:	10/08/2015	**Date of Injury:**	10/02/2014
Decision Date:	11/24/2015	**UR Denial Date:**	09/30/2015
Priority:	Standard	**Application Received:**	10/02/2015

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: Physical Medicine & Rehabilitation

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 56 year old female with a date of injury of October 2, 2014. A review of the medical records indicates that the injured worker is undergoing treatment for lumbosacral radiculitis, coccyx pain, lower back pain, and headache. Medical records dated July 14, 2015 indicate that the injured worker complained of worsening lower back pain that radiates down the back of the left leg with occasional numbness in the lateral left foot and toes. A progress note dated September 18, 2015 documented complaints similar to those reported on July 14, 2015. Per the treating physician (July 14, 2015), the employee last worked on June 23, 2015. The physical exam dated July 14, 2015 reveals tenderness in the central back at L3, L4, and L5, and pain and discomfort with lumbar range of motion. The progress note dated September 18, 2015 documented a physical examination that showed left paraspinous muscle spasm, "Incredibly limited range of motion about the lumbosacral spine", positive straight leg raise on the left with severe pain down the leg to the foot, and grossly limited toe raise and heel gait due to pain. Treatment has included magnetic resonance imaging of the lumbar spine that showed mild degeneration of the discs at L5-S1 and L4-L5, lumbar epidural steroid injection, unknown number of chiropractic treatments, unknown number of physical therapy sessions, and medications (Gabapentin since at least April of 2015; Relafen since at least June of 2015). The original utilization review (September 30, 2015) non-certified a request for six sessions of physical therapy for the lumbar spine and a sympathetic nerve block.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 3 weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Physical therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: The 56 year old patient complains of lower back and severe left leg pain with reduced range of motion, as per progress report dated 09/18/15. The request is for Physical therapy 2 times a week for 3 weeks for the lumbar spine. The RFA for this case is dated 09/28/15, and the patient's date of injury is 10/02/14. Medications, as per progress report dated 09/18/15, included Relafen, Gabapentin and Estrogen. EMG/NCV, dated 08/24/15, revealed mild abnormalities suggesting the possibility of a S1 root irritation with acute radiculopathy. The patient is temporarily totally disabled, as per progress report dated 09/18/15. MTUS Chronic Pain Management Guidelines 2009, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." In this case, the request for 6 sessions of physical therapy is noted in progress report dated 09/18/15. The treater is also requesting for a re-evaluation by [redacted], a pain management specialist, for a sympathetic block or an epidural steroid injection. The treater states that the "physical therapy will follow the treatment" by [redacted] Neither the progress reports nor the Utilization Review denial letter document the number of physical therapy session completed until now or their efficacy in terms of reduction in pain and improvement in function. Additionally, the treater does not explain why the patient has not transitioned to a home exercise regimen. MTUS allows for 8-10 sessions of physical therapy in non-operative cases. However, given the lack of relevant documentation regarding prior therapy, the request IS NOT medically necessary.

Sympathetic nerve block: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, & lumbar sympathetic block). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Sympathetic blocks.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Complex Regional Pain Syndrome (CRPS), Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back Chapter under diagnostic epidural steroid transforaminal injections.

Decision rationale: The 56 year old patient complains of lower back and severe left leg pain with reduced range of motion, as per progress report dated 09/18/15. The request is for Sympathetic nerve block. The RFA for this case is dated 09/28/15, and the patient's date of injury is 10/02/14. Medications, as per progress report dated 09/18/15, included Relafen, Gabapentin and Estrogen. EMG/NCV, dated 08/24/15, revealed mild abnormalities suggesting

the possibility of a S1 root irritation without acute radiculopathy. The patient is temporarily totally disabled, as per progress report dated 09/18/15. MTUS Guidelines, CRPS, sympathetic and epidural blocks Section, pages 39-40 has the following "Recommended only as indicated below, for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. Repeated blocks are only recommended if continued improvement is observed. Systematic reviews reveal a paucity of published evidence supporting the use of local anesthetic sympathetic blocks for the treatment of CRPS and usefulness remains controversial. Less than 1/3 of patients with CRPS are likely to respond to sympathetic blockade. No controlled trials have shown any significant benefit from sympathetic blockade." "Predictors of poor response: Long duration of symptoms prior to intervention; Elevated anxiety levels; Poor coping skills; Litigation." MTUS p103-104 also states: "Regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, & lumbar sympathetic block). Recommendations are generally limited to diagnosis and therapy for CRPS. Stellate ganglion block (SGB) (Cervicothoracic sympathetic block): There is limited evidence to support this procedure, with most studies reported being case studies." MTUS Guidelines has the following regarding ESI under chronic pain section page 46 and 47, "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." The MTUS Criteria for the use of Epidural steroid injections states: "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In addition, MTUS states that the patient must be "Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs and muscle relaxants.)" ODG guidelines Low back Chapter under diagnostic epidural steroid transforaminal injections states: "Recommended in selected cases as indicated below. Diagnostic epidural steroid transforaminal injections are also referred to as selective nerve root blocks, and they were originally developed, in part, as a diagnostic technique to determine the level of radicular pain. The role of these blocks has narrowed with the advent of MRIs. Few studies are available to evaluate diagnostic accuracy or post-surgery outcome based on the procedure and there is no gold standard for diagnosis. No more than 2 levels of blocks should be performed on one day. The response to the local anesthetic is considered an important finding in determining nerve root pathology. (CMS, 2004)" In this case, there is no indication of a prior sympathetic nerve block. A request for re-evaluation by [redacted] a pain management specialist, for a sympathetic block or an epidural steroid injection is noted in progress report dated 09/18/15. In progress report dated 06/30/15, [redacted] states a "potential differential diagnoses due to her symptoms would include arachnoiditis/myelitis potentially of viral origin and CRPS type 1." The treater recommends an EMG/NCV and indicates "in case of a CRPS a left lumbar sympathetic block may have diagnostic value as well as perhaps therapeutic value." EMG/NCV, dated 08/24/15, revealed mild abnormalities suggesting the possibility of a S1 root irritation without acute radiculopathy. Physical examination, as per progress report dated 09/18/15, revealed very positive straight leg raise wit h severe pain all the way down her left leg to the foot. Given the neuropathic pain, a sympathetic nerve block appears reasonable as it may aid in further diagnoses and treatment. Therefore, the request IS medically necessary.