

<b>Case Number:</b>	CM15-0215911		
<b>Date Assigned:</b>	11/05/2015	<b>Date of Injury:</b>	07/22/2012
<b>Decision Date:</b>	12/18/2015	<b>UR Denial Date:</b>	10/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2015

### 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, Indiana, New York  
 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 07-22-2012. According to a progress report dated 09-28-2015, the injured worker had a cervical epidural steroid injection 2 weeks prior. Following the injection, his neck pain completely resolved for about a day and a half before returning to baseline. The numbness in the radial digits of both hands did not improve with the epidural. Electrodiagnostic studies from 06-17-2014 showed borderline median carpal tunnel syndrome and chronic right C5-6 radiculopathy. He currently had ongoing neck pain that radiated into his shoulder blades down the bilateral forearms with numbness into the fingers. Neck symptoms were rated 10 out of 10 in intensity with or without medications. Hand symptoms was rated 8-9 out of 10. He had ongoing low back pain with numbness and tingling in the right anterior thigh ending at the knee. He had difficulty with toileting, standing, sitting, reclining, walking, grasping, lifting, tactile discrimination and sleep. Current medications include Prilosec and Tylenol with Codeine. There was decreased sensation over the bilateral C6 dermatome distribution. Orthopedic testing of the cervical spine revealed local pain. Motor power was noted as trace with right wrist extension. There was decreased sensation over the right L5 and right S1 dermatome distributions. Straight leg raise was positive bilaterally at 90 degrees. There was no palpable tenderness of the paravertebral muscles bilaterally. There was no evidence of tenderness over the sacroiliac joint bilaterally. There was no tenderness over the sciatic notches. There was no tenderness over the flanks bilaterally. There was no tenderness over the coccyx. Assessment included right shoulder impingement syndrome, cervical strain with a C5-6 disc degeneration, C5-6 stenosis, and intermittent C6

radiculopathy versus carpal tunnel cubital tunnel syndrome, L5-S1 disc degeneration, intermittent lumbar radiculopathy and spontaneous deep vein thrombosis. The treatment plan included updated MRI scan of the cervical spine. The provider noted that the last MRI scan was over one year ago. In regards to the lumbar spine, the provider noted that the injured worker had not had therapy. Recommendations included physical therapy for the lumbar spine and pain management consultation and facet blocks at L5-S1. The injured worker was temporarily totally disabled. On 10-13-2015, Utilization Review non-certified the request for physical therapy 2-3 times a week for 4 weeks for the lumbar spine, updated MRI scan of the cervical spine and pain management consultation with facet blocks at L5-S1.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Physical therapy 2-3 times a week for 4 weeks for the lumbar spine:** Upheld

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

**MAXIMUS 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 section, Physical therapy.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy 2 to 3 times per week times 4 weeks to the lumbar spine is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are right shoulder impingement syndrome; cervical strain with C5 - C6 disc degeneration; C5 - C6 stenosis; intermittent C6 radiculopathy versus carpal tunnel/cubital tunnel syndrome; L5 - S1 disc degeneration; intermittent lumbar radiculopathy; and spontaneous DVT. Date of injury is July 22, 2012. Request for authorization is October 6, 2015. According to a September 28, 2015 progress note, the injured worker has ongoing neck pain that radiates to the bilateral shoulder blades and forearms with numbness. Pain is 10/10 with and without medications. Additional subjective complaints include low back pain with numbness and tingling that radiates to the right anterior thigh. The injured worker had a cervical epidural steroid injection with symptom resolution for 1.5 days. EMG/NCVs were performed that showed bilateral carpal tunnel syndrome and chronic right C5 - C6 radiculopathy. Objectively, there is decreased sensation in the bilateral C6 dermatomes and right L5 and S1 dermatomes. Motor function is 5/5. There is no tenderness present. An MRI of the cervical spine was performed March 7, 2014. There is no documentation of prior physical therapy in the medical record. The total number of physical therapy sessions is not specified in the record. There is no documentation demonstrating objective functional improvement from prior physical therapy. There are no compelling clinical facts indicating additional physical therapy over the recommended guidelines is clinically indicated. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation of prior physical therapy or

documentation demonstrating objective functional improvement and no compelling clinical facts indicating additional physical therapy is clinically indicated, physical therapy 2 to 3 times per week times 4 weeks to the lumbar spine is not medically necessary.

**Updated MRI scan of cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Cervical Chapter - Magnetic Resonance imaging (MRI).

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, MRI cervical spine.

**Decision rationale:** Pursuant to the ACOEM and the Official Disability Guidelines, updated MRI scan of the cervical spine is not medically necessary. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness with no neurologic findings do not need imaging. Patients who do not fall into this category should have a three view cervical radiographic series followed by a computer tomography (CT). The indications for imaging are enumerated in the Official Disability Guidelines. Indications include, but are not limited to, chronic neck pain (after three months conservative treatment), radiographs normal neurologic signs or symptoms present; neck pain with radiculopathy if severe or progressive neurologic deficit; etc. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). The criteria for ordering an MRI of the cervical spine include the emergence of a red flag, physiologic evidence of tissue insult when nerve impairment, failure to progress in a strengthening program intended to avoid surgery and clarification of anatomy prior to surgery. In this case, the injured worker's working diagnoses are right shoulder impingement syndrome; cervical strain with C5 - C6 disc degeneration; C5 - C6 stenosis; intermittent C6 radiculopathy versus carpal tunnel/cubital tunnel syndrome; L5 - S1 disc degeneration; intermittent lumbar radiculopathy; and spontaneous DVT. Date of injury is July 22, 2012. Request for authorization is October 6, 2015. According to a September 28, 2015 progress note, the injured worker has ongoing neck pain that radiates to the bilateral shoulder blades and forearms with numbness. Pain is 10/10 with and without medications. Additional subjective complaints include low back pain with numbness and tingling that radiates to the right anterior thigh. The injured worker had a cervical epidural steroid injection with symptom resolution for 1.5 days. EMG/NCVs were performed that showed bilateral carpal tunnel syndrome and chronic right C5 - C6 radiculopathy. Objectively, there is decreased sensation in the bilateral C6 dermatomes and right L5 and S1 dermatomes. Motor function is 5/5. There is no tenderness present. An MRI of the cervical spine was performed March 7, 2014. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). The

documentation states the treating provider wants to update the cervical MRI because the last one was one year old. There is no clinical rationale or indication for repeating the MRI cervical spine. There are no significant changes in symptoms and/or objective findings suggestive of significant pathology. The injured worker has ongoing chronic pain. There are no unequivocal objective findings (other than established radiculopathy per EMG/NCV) that identifies specific nerve compromise. Based on clinical information the medical record, peer-reviewed evidence-based guidelines, no new significant symptoms and/or objective findings that identify specific pathology and no unequivocal objective findings that identify specific nerve compromise (new changes), and no clinical rationale for repeating MRI cervical spine, updated MRI scan of the cervical spine is not medically necessary.

**Pain management consultation with facet blocks at L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, facet joint diagnostic blocks (injections) section, ACOEM, Chapter 7, Independent Medical Examinations and Consultations.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): General Approach, Initial Care, Surgical Considerations.

**Decision rationale:** Pursuant to the ACOEM, pain management consultation with facet blocks at L5 - S1 is not medically necessary. An occupational health practitioner may refer to other specialists if the diagnosis is certain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultation is designed to aid in the diagnosis, prognosis and therapeutic management of a patient. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medications such as opiates for certain antibiotics require close monitoring. In this case, the injured worker's working diagnoses are right shoulder impingement syndrome; cervical strain with C5 - C6 disc degeneration; C5 - C6 stenosis; intermittent C6 radiculopathy versus carpal tunnel/cubital tunnel syndrome; L5 - S1 disc degeneration; intermittent lumbar radiculopathy; and spontaneous DVT. Date of injury is July 22, 2012. Request for authorization is October 6, 2015. According to a September 28, 2015 progress note, the injured worker has ongoing neck pain that radiates to the bilateral shoulder blades and forearms with numbness. Pain is 10/10 with and without medications. Additional subjective complaints include low back pain with numbness and tingling that radiates to the right anterior thigh. The injured worker had a cervical epidural steroid injection with symptom resolution for 1.5 days. EMG/NCVs were performed that showed bilateral carpal tunnel syndrome and chronic right C5 - C6 radiculopathy. Objectively, there is decreased sensation in the bilateral C6 dermatomes and right L5 and S1 dermatomes. Motor function is 5/5. There is no tenderness present. An MRI of the cervical spine was performed March 7, 2014. Facet blocks are indicated when pain is non-radicular. The documentation indicates the injured worker has subjective complaints of radiculopathy involving the lower extremities and objective evidence of radiculopathy in the lower extremities. Facet blocks and L5 - S1 are not clinically indicated and, as a result, a pain management consultation with facet

blocks at L5 - S1 is not clinically indicated. Based on clinical information in the medical record and the peer-reviewed evidence-based guidelines, pain management consultation with facet blocks at L5 - S1 is not medically necessary.