

<b>Case Number:</b>	CM15-0039507		
<b>Date Assigned:</b>	03/10/2015	<b>Date of Injury:</b>	12/05/2005
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2015

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 (IW) is a 60 year old female, who sustained an industrial injury as a result of continuous trauma on 12/05/2005. She reported pain in the right shoulder, lumbosacral spine, right hip, right hip, bilateral knees and left ankle. The injured worker was diagnosed as having contusion /sprain with hematoma and possibly injury/tear of the vastus medialis oblique ; status post total knee resurfacing arthroplasty and wound revision, right knee, 09/02/2008 ; status post knee replacement revision with dislocated patella, lateral release and scar revision, left knee, 10/03/2011; status post prior arthroscopy with lateral release, 02/23/2011; status post prior total left knee arthroplasty, 11/16/2009; Left S1 radiculopathy, per EMG, multiple lumbar disk bulges with bilateral foraminal stenosis Lumbar 3-4-5; Grade 1 spondylolisthesis with no compression over the L5 nerve roots per MRI 08/2012; status post anterior lumbar interbody decompression and fusion L5-S1, 03/23/2009. The Diagnoses also include right hip trochanteric bursitis and gluteal tenderness secondary to overcompensation for left knee; right shoulder sprain/strain, type II acromioclavicular joint and acromioclavicular undersurface spurs with mild impingement; suspected supraspinatus tendon tear, per MRI 04/20/2010. Currently, the injured worker complains of pain in the lumbar spine, both knees, right shoulder, and right hip. The pain is described as constant slight, intermittent moderate and occasionally severe. She notes numbness and tingling in the lower extremities with prolonged sitting or standing. The right hip hurts with prolonged sitting, and both knees have weakness with occasional popping and clicking. She also complains of right shoulder stiffness, popping and clicking and she has difficulty with overhead activities. Treatment recommendations include physical therapy, twelve (12) Sessions two times

a week for 6 weeks lumbar spine and bilateral knees RFA 01/19/2015, Lumbar epidural steroid injection #2 time with request for authorization (RFA) on 1/19/2015, and right shoulder MRI times one RFA on 01/19/2015. Also requested were physical therapy, twelve (12) Sessions two times a week for 6 weeks lumbar spine and bilateral knees RFA on 12/1/2014, and Right shoulder MRI times 1 RFA on 12/01/2014.

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

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

**Lumbar epidural steroid injection #2 times:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of epidural steroid injection.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESIs Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ESIs.

**Decision rationale:** Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in a dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Research has shown that, on average, less than two injections are required for a successful ESI outcome. ESIs can offer short-term pain relief and use should be in conjunction with other rehab efforts. The purpose of ESIs is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. CA MTUS guidelines state radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, the patient received a previous lumbar ESI with improvement of low back pain, but the duration of relief was not documented. In addition, the lumbar levels for the requested ESIs are not specified. Medical necessity for the requested services have not been established. The requested lumbar epidural steroid injections (#2) are not medically necessary.

**Physical therapy; twelve (12) Sessions two time a week for 6 weeks lumbar spine and bilateral knees:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. This patient's industrial injury occurred on 12/05/2005. The patient reported pain in the right shoulder, lumbosacral spine, right hip, right hip, bilateral knees and left ankle. The patient is status post bilateral total knee arthroplasties (2008, 2009). In this case, the patient's back and knee injuries are chronic, and physical therapy has been performed in the past without noted functional improvement. More recently, on 08/07/14, the patient was approved to participate in 8 sessions of physical therapy for the lumbar spine and bilateral knees. There was improvement in stiffness/pain bilaterally after 3 sessions, however, no documentation of functional improvement. There is no rationale provided for continued supervised therapy sessions (2x6 lumbar spine and bilateral knees). Medical necessity for the requested additional physical therapy sessions has not been established. The requested sessions are not medically necessary.

**Physical therapy; twelve (12) Sessions two time a week for 6 weeks lumbar spine and bilateral knees:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. This patient's industrial injury occurred on 12/05/2005. The patient reported pain in the right shoulder, lumbosacral spine, right hip, right hip, bilateral knees and left ankle. The patient is status post bilateral total knee arthroplasties (2008, 2009). In this case, the patient's back and knee injuries are chronic, and physical therapy has been performed in the past without noted functional improvement. More recently, on 08/07/14, the patient was approved to participate in 8 sessions of physical therapy for the lumbar spine and bilateral knees. There was improvement in stiffness/pain bilaterally after 3 sessions, however, no documentation of functional improvement. There is no rationale provided for continued supervised therapy sessions (2x6 lumbar spine and bilateral knees). Medical necessity for the requested additional physical therapy sessions has not been established. The requested sessions are not medically necessary.

**Right shoulder MRI times 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209, Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG) shoulder chapter MRI.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MRI of the shoulder.

**Decision rationale:** The ODG states that an MRI of the shoulder is indicated for the evaluation of acute shoulder trauma, suspected rotator cuff tear/impingement, in patients over age 40 with normal plain radiographs, subacute shoulder pain, and suspected instability/labral tear. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, the patient had a suspected right supraspinatus tendon tear on MRI on 04/20/10, but the actual report is not included in the medical records. On 03/31/14, a diagnostic ultrasound of the right shoulder demonstrated increased signal in the supraspinatus tendon consistent with tendinosis and possible partial tear. There is no discussion of surgery or emergence of any red flag findings on exam to warrant another (second) MRI of the right shoulder. Medical necessity for the requested MRI is not established. The requested study is not medically necessary.

**Right shoulder MRI times on:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209, Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG) shoulder chapter MRI.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MRI of the right shoulder.

**Decision rationale:** The ODG states that an MRI of the shoulder is indicated for the evaluation of acute shoulder trauma, suspected rotator cuff tear/impingement, in patients over age 40 with normal plain radiographs, subacute shoulder pain, and suspected instability/labral tear. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, the patient had a suspected right supraspinatus tendon tear on MRI on 04/20/10, but the actual report is not included in the medical records. On 03/31/14, a diagnostic ultrasound of the right shoulder demonstrated increased signal in the supraspinatus tendon consistent with tendinosis and possible partial tear. There is no discussion of surgery or emergence of any red flag findings on exam to warrant another MRI of the right shoulder. Medical necessity for the requested MRI is not established. The requested study is not medically necessary.