

Case Number:	CM15-0059100		
Date Assigned:	04/17/2015	Date of Injury:	04/16/2004
Decision Date:	08/18/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/27/2015

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: 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 56-year-old female, who sustained an industrial injury on April 16, 2004. She reported neck pain from a fall. The injured worker was diagnosed as having cervical degenerative disc disease, lumbar degenerative disc disease, chronic headaches likely cervicogenic, multiple joint pain (bilateral wrists, knees, and ankles), and depression. Treatment to date has included chiropractic treatments, aqua therapy, MRIs, and medication. Currently, the injured worker complains of neck and right shoulder and right arm pain, headaches, low back pain, bilateral wrist pain, and bilateral knee pain. The Treating Physician's report dated February 18, 2015, noted the injured worker reported her pain level worse since the previous visit. A cervical spine MRI was noted to show multilevel degenerative changes. Current pain medications were noted to include Voltaren gel and Ibuprofen. Physical examination was noted to show marked tenderness in the cervical spine, marked tenderness over the bilateral greater occipital nerves, marked tenderness over both wrists, both ankles, and both knees, and marked tenderness in the midline of the lower lumbar spine. The treatment plan included MRI of the cervical and lumbar spine, cervical and lumbar spine epidural steroid injection (ESI), medications, a scooter/power chair, chiropractic treatments, rheumatologist referral, referral to a psychiatrist, and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, MRIs (magnetic resonance imaging).

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

Decision rationale: As per Official Disability Guidelines (ODG)-MRI (magnetic resonance imaging) is indicated for Lumbar spine trauma, neurological deficit, Thoracic spine trauma: with neurological deficit, Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit), Uncomplicated low back pain, suspicion of cancer, infection, other "red flags", Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit, Uncomplicated low back pain, prior lumbar surgery, Uncomplicated low back pain, cauda equina syndrome, Myelopathy (neurological deficit related to the spinal cord), traumatic Myelopathy, painful Myelopathy, sudden onset, Myelopathy, stepwise progressive, Myelopathy, slowly progressive, Myelopathy, infectious disease patient, Myelopathy, oncology patient. Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, and recurrent disc herniation). The injured worker complains of neck and right shoulder and right arm pain, headaches, low back pain, bilateral wrist pain, and bilateral knee pain. As per progress notes in the Medical Records, the injured worker does not appear to have significant changes in symptoms and signs, no documentation of concerning changes in her neurological exam, and there are no red flags. Without such evidence and based on guidelines cited, the request for repeat MRI of the Lumbar spine is not medically necessary and appropriate.

Cervical Epidural Steroid Injection (PIA states no levels because of Catheter): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

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

Decision rationale: This requested treatment for Epidural steroid injections (ESIs) is evaluated in light of the CA MTUS and the Official Disability Guidelines (ODG) recommendations. The California MTUS Chronic Pain Medical Treatment Guidelines recommend epidural steroid injections as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 epidural steroid injections. Current recommendations suggest a second epidural injection if partial success is produced with the first injection. Epidural steroid injections can offer short-

term pain relief and use should be in conjunction with other rehab efforts, including continuing with home exercise. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement of radicular lumbosacral pain, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendations for use of epidural steroid injections to treat radicular cervical pain." ODG criteria do not recommend additional epidural steroid injections, if significant improvement is not achieved with an initial treatment. ODG also state there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. Review of medical documentation does not specify neurological deficits within a dermatomal pattern. The notes from treating provider do not indicate abnormal neurological exam. There is no evidence of nerve entrapment or radiculopathy. Based on the cited guidelines and the submitted documentation, the request for cervical epidural injection is not medically necessary.

Lumbar Epidural Steroid Injection L4-5, L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

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

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines recommend epidural steroid injections as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 epidural steroid injections. Current recommendations suggest a second epidural injection if partial success is produced with the first injection. Epidural steroid injections can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing with home exercise. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement of radicular lumbosacral pain, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendations for use of epidural steroid injections to treat radicular cervical pain." ODG criteria do not recommend additional epidural steroid injections, if significant improvement is not achieved with an initial treatment. The treating provider documents "reduced sensation to light touch along the anterior and lateral left thigh and the posterior left leg" In the submitted documentation for review, there are no provocative tests that suggest radiculopathy. Imaging reports are also neither conclusive nor corroborative. The requested treatment Lumbar Epidural Steroid Injection L4-5, L5-S1 is not medically necessary and appropriate.

Chiropractic x 12 for Neck: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: Per MTUS guidelines, it is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Review of the Medical Records indicate no clear functional benefit, this injured worker had, from prior Chiropractic visits, therefore, the request for Chiropractic therapy is not medically necessary and appropriate.

Chiropractic Treatment x 12 for Low Back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: Per MTUS guidelines, it is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Review of the Medical Records indicate no clear functional benefit, this injured worker had, from prior Chiropractic visits, therefore, the request for Chiropractic therapy is not medically necessary and appropriate.

Chiropractic Treatment x 12 for Bilateral Knees: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: Per MTUS guidelines, it is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive

symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. MTUS guidelines further state, manual therapy and manipulation of knee is not recommended, therefore, the request for Chiropractic Treatment x 12 for Bilateral Knees is not medically necessary and appropriate.

Physical Therapy x 12 for Neck Only: Upheld

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

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

Decision rationale: The prescription for Physical Therapy is evaluated in light of the MTUS recommendations for Physical Therapy: MTUS recommends 1) Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 2) 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The records indicate the injured worker had no functional benefit from prior physical therapy visits. In addition, there is no mention of any significant change of symptoms or clinical findings, or acute flare up to support PT. The request for physical therapy is not medically necessary and appropriate.

Mobility Aid/Scooter or Power Chair: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs). Decision based on Non-MTUS Citation Official Disability Guidelines, Knee Chapter, Power mobility devices (PMDs).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter--Power mobility devices (PMDs)--Durable medical equipment (DME).

Decision rationale: Official Disability Guidelines (ODG) do not recommend power mobility devices if the functional mobility deficit can be sufficiently resolved by the prescription of a cane

or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. Official Disability Guidelines (ODG) state Durable medical equipment (DME) is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME). Medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. The treating provider notes that this injured worker has normal gait, 5/5 both upper extremities: all muscle groups, 5/5 right lower extremity, 4/5 left lower extremity; all muscle groups. With the documentation provided for review, and the guidelines cited above, the requested treatment Mobility Aid/Scooter or Power Chair is not medically necessary and appropriate.