| Case Number: | CM15-0076650 | | |
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| Date Assigned: | 05/05/2015 | Date of Injury: | 04/15/2013 |
| Decision Date: | 09/04/2015 | UR Denial Date: | 03/23/2015 |
| Priority: | Standard | Application Received: | 04/22/2015 |

## 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 39 year old male, who sustained an industrial injury on 04/15/2013. He has reported subsequent back, wrist, and hand pain, numbness and tingling and was diagnosed with carpal tunnel syndrome, lumbar facet arthropathy and chronic pain syndrome. Treatment to date has included oral pain medication, cognitive behavioral therapy, pool therapy and physical therapy. In a progress note dated 03/03/2015, the injured worker complained of neck, back, bilateral wrist, and lower extremity pain. There were no detailed objective examination findings documented during this visit. A request for authorization of lumbar epidural steroid injection, rental or purchase of PENS and supplies, aqua therapy for cervical, thoracic, lumbar spine, left knee and right wrist 2x6, physical therapy for the cervical, thoracic, lumbar spine, left knee and right wrist 2x6 and follow up evaluation with a pain medicine specialist, sleep study specialist, internal medicine specialist, urologist and orthopedic spine specialist was submitted.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar epidural injection:** 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 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 electrodiagnostic 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 injured worker has chronic Low Back 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 documented by physical exam and corroborated by imaging studies and/or electrodiagnostic testing. Based on the cited guidelines and the submitted documentation, the request for Lumbar epidural injection is not medically necessary.

**Rental or purchase of PENS (P-stim) and supplies:** 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 Percutaneous electrical nerve stimulation (PENS) Page(s): 97.

**Decision rationale:** As per MTUS Percutaneous electrical nerve stimulation (PENS) is not recommended as a primary treatment modality, but a trial may be considered, if used as an adjunct to a program of evidence-based functional restoration, after other non-surgical treatments, including therapeutic exercise and TENS, have been tried and failed or are judged to be unsuitable or contraindicated. There is a lack of high quality evidence to prove long-term efficacy. Percutaneous electrical nerve stimulation (PENS) is similar in concept to transcutaneous electrical nerve stimulation (TENS) but differs in that needles are inserted to a depth of 1 to 4 cm either around or immediately adjacent to the nerve serving the painful area and then stimulated. PENS is generally reserved for patients who fail to get pain relief from TENS, apparently due to obvious physical barriers to the conduction of the electrical stimulation (e.g., scar tissue, obesity). In this case there is no documentation of using TENS in the past. Based on the information within the submitted medical records and guidelines cited, the requested treatment, Rental or purchase of PENS (P-stim) and supplies is not medically necessary and appropriate.

**Aqua therapy for cervical, thoracic, lumbar, left knee, right wrist 2x6:** 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 Aquatic therapy Page(s): 22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Aquatic therapy.

**Decision rationale:** Both MTUS and ODG recommend Aquatic Therapy as an optional form of exercise therapy, where available, as an alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. In this case, review of submitted medical records lack clinical data to support the request. Also it is not clear what the outcome of prior Aquatic Therapy was. Therefore, the Requested Treatment, Aquatic Therapy Sessions is not medically necessary and appropriate.

**Follow-up evaluation with a pain medicine specialist:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Office visits.

**Decision rationale:** Official Disability Guidelines (ODG) recommends office visits as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the 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 medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment. Physician may refer to other specialists if diagnosis is complex or extremely complex. Consultation is used to aid in the diagnosis, prognosis, therapeutic management, and determination of medical stability. The notes submitted by treating provider do not indicate why referral is needed. Medical records are not clear about any change in the injured worker's chronic symptoms. The treating provider does not specify what the concerns are that need to be addressed by the specialist. Given the lack of documentation and considering the guidelines, the request is not medically necessary.

**Physical therapy for cervical, thoracic, lumbar, left knee, right wrist 2x6:** 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): 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. Also there is no mention of any significant change of symptoms or clinical findings, or acute flare up to support PT. The Requested Treatment, Physical therapy for cervical, thoracic, lumbar, left knee, and right wrist 2x6 is not medically necessary and appropriate.

**Follow-up with a sleep study specialist:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Office visits.

**Decision rationale:** Official Disability Guidelines (ODG) recommends office visits as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the 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 medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment. Physician may refer to other specialists if diagnosis is complex or extremely complex. Consultation is used to aid in the diagnosis, prognosis, therapeutic management, and determination of medical stability. The notes submitted by treating provider do not indicate why referral is needed. Medical records are not clear about any change in injured worker's chronic symptoms. The treating provider does not specify what the concerns are that need to be addressed by the specialist. The injured worker had sleep evaluation, however the report cannot be located in the submitted records. There is lack of clear information concerning sleep issues. Given the lack of documentation and considering the guidelines, the request is not medically necessary.

**Follow-up evaluation with internal medicine specialist:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Office visits.

**Decision rationale:** Official Disability Guidelines (ODG) recommends office visits as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the 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 medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment. Physician may refer to other specialists if diagnosis is complex or extremely complex. Consultation is used to aid in the diagnosis, prognosis, therapeutic management, and determination of medical stability. The notes submitted by treating provider do not indicate why referral is needed. Medical records are not clear about any change in injured worker's chronic symptoms. The treating provider note dated March 12, 2015 mentions abdominal pain improving, and normal abdominal exam. Records do not specify what the concerns are that need to be addressed by the specialist. Given the lack of documentation and considering the guidelines, the request is not medically necessary.

**Follow-up with an urologist:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Office visits.

**Decision rationale:** Official Disability Guidelines (ODG) recommends office visits as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the 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 medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment. Physician may refer to other specialists if diagnosis is complex or extremely complex. Consultation is used to aid in the diagnosis, prognosis, therapeutic management, and determination of medical stability. The notes submitted by treating provider do not indicate why referral is needed. Medical records are not clear about any change in injured worker's chronic symptoms. The treating provider does not specify what the concerns are that need to be addressed by the specialist. It is not clear what the outcome was of prior evaluation, if any. Given the lack of documentation and considering the guidelines, the request is not medically necessary.

**Follow-up with an orthopedic spine specialist:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Office visits.

**Decision rationale:** Official Disability Guidelines (ODG) recommends office visits as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the 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 medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment. Physician may refer to other specialists if diagnosis is complex or extremely complex. Consultation is used to aid in the diagnosis, prognosis, therapeutic management, and determination of medical stability. The notes submitted by treating provider do not indicate why referral is needed. Medical records are not clear about any change in injured worker's chronic symptoms. The treating provider does not specify what the concerns are that need to be addressed by the specialist. Given the lack of documentation and considering the guidelines, the request is not medically necessary.