

Case Number:	CM14-0122815		
Date Assigned:	09/16/2014	Date of Injury:	03/19/2009
Decision Date:	10/16/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	08/04/2014

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in North Carolina. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 57-year-old with a reported date of injury of 03/19/2009. The patient has the diagnoses of cervicalgia, lumbar pain, post cervical spinal fusion, cervical radiculopathy, lumbar radiculopathy and lumbar degenerative disc disease. Past treatment modalities have included acupuncture, physical therapy and surgery. Per the most recent progress reports provided for review by the treating physician dated 08/18/2014, the patient had complaints of chronic neck pain characterized as aching, dull and throbbing and chronic low back pain. The physical exam noted pain with range of motion in the cervical and lumbar spine. Sensation was decreased to pinprick in the right foot and right lower extremity. Treatment plan recommendations included lumbar x-ray, lumbar bilateral steroid injections and continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-ray Lumbar Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: The ACOEM chapter on low back complaints and imaging states: Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. In this case the physician ordered the lumbar x-ray because the patient felt something move in her back at night. There was no documentation of new abnormalities in the physical exam. There was no evidence of red flag pathology or suspicion for fracture noted. For these reasons criteria for lumbar x-ray have not been met per the ACOEM. Therefore the request is not medically necessary.

Lumbar Epidural Steroid Injection (ESI) X 3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) Epidural Steroid Injections

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46.

Decision rationale: The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: Criteria for the use of Epidural steroid injections: Note: The purpose of ESI 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. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a "series-of-three" injection in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. This patient does have a diagnosis of radicular pain and corroboration by lumbar MRI of nerve compromise. There is also documentation of failure of other conservative measures such as acupuncture. However the guidelines do not recommend more than 2 ESI and the request is for a quantity of 3. For these reasons the criteria set forth above have not been met. Therefore the request is not medically necessary.

Physical Therapy x 6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Pain, Suffering , and the Restoration of Function Chapter, page 114

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

Decision rationale: The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. 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 therehabilitation process. 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 treatmentprocess in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of activetreatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)Physical Medicine Guidelines -Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeksNeuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeksReflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeksWhile physical medicine is a recommended therapy for the treatment of chronic pain per the California MTUS, the provided documentation and the request do not specify what the physical therapy actually is for in terms of treatment. The patient has also already completed some physical therapy but the included progress notes do not indicate how many sessions. Without knowing what condition the physical therapy is being prescribed for and whether or not the patient has already completed the recommended number of sessions per the California MTUS, the request is not medically necessary.