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| Case Number: | CM15-0110041 | | |
| Date Assigned: | 06/16/2015 | Date of Injury: | 10/02/2014 |
| Decision Date: | 07/15/2015 | UR Denial Date: | 05/19/2015 |
| Priority: | Standard | Application Received: | 06/08/2015 |

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 41 year old female, who sustained an industrial injury on October 2, 2014. She reported pain in her low back, arms and bilateral legs. Treatment to date has included modified work duties, physical therapy, chiropractic therapy, MRI of the lumbar spine, pain management consultation and medications. Currently, the injured worker complains of pain in the bilateral shoulders with pain radiating to her bilateral arms. She reports cracking and loss of range of motion in the right shoulder and notes that her shoulder pain is increased with activities such as lifting, carrying heavy items, and reaching. She reports intermittent pain in her bilateral hands and notes that the pain is increased with holding hot items or lifting heavy items. She reports constant pain to the low back and notes she has associated numbness and tingling. She reports intermittent pain in the right knee and the pain is increased with weight-bearing and prolonged walking. The injured worker has bilateral foot pain and reports that prolonged walking, standing, weight-bearing and tight shoes aggravate the pain. On physical examination the injured worker has tenderness to palpation over the bilateral shoulder and the cervical spine. Her bilateral shoulder range of motion is within normal limits and she is without impingement or crepitus bilaterally. Sensation is intact in the upper extremities. The injured worker ambulates with a normal gait and is able to walk on her heels and her toes without difficulty. She has a limited range of motion of the lumbar spine and has a positive straight leg raise test on the right. Her sensation is intact in the bilateral lower extremities. Examination of her bilateral knees reveals tenderness to palpation over the bilateral medial aspect of the knee. Her bilateral range of motion is within normal limits and she has negative Lachman's test and McMurray's test

bilaterally. She has tenderness to palpation over the bilateral feet/ankles and has normal range of motion of the bilateral ankles. She has normal sensation and motor power of the bilateral feet/ankles and Tinel's sign is negative bilaterally. An x-ray of the lumbar spine revealed central disc protrusion with an annular fissure of the lumbar spine at L5 and an L5-S1 left foraminal disc protrusion with annular fissure. The diagnoses associated with the request include shoulder sprain, knee sprain, feet sprain, lumbar spine radiculopathy and bilateral hand strain. The treatment plan includes physical therapy for the shoulders, knees, lumbar spine and feet, x-rays of the shoulders, knees, hand and feet, lumbar epidural steroid injection series, Motrin, Tramadol and home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy two times a week for four weeks for the lumbar spine, bilateral shoulder, bilateral knee, bilateral feet: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical therapy Page(s): 98-99. Decision based on Non-MTUS Citation ACOEM Chapter 6 Page 114, Pain, Suffering, and the Restoration of Function Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy two times a week for four weeks for the lumbar spine, bilateral shoulder, bilateral knee, bilateral feet is not medically necessary and appropriate.

Lumbar epidural steroid injection at L4-L5: 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, page 46.

Decision rationale: There were no neurologic deficits documented with objective findings of tenderness and restricted range. MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); However, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not provided here. In addition, to repeat a LESI 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. Submitted reports have not demonstrated any failed conservative treatment trial for this chronic injury without flare-up, change in clinical findings or new injuries identified. Criteria for the LESI have not been met or established. The Lumbar epidural steroid injection at L4-L5 is not medically necessary and appropriate.