

Case Number:	CM15-0119503		
Date Assigned:	06/30/2015	Date of Injury:	11/29/2012
Decision Date:	08/25/2015	UR Denial Date:	05/29/2015
Priority:	Standard	Application Received:	06/22/2015

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: 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:

This 57 year old male sustained an industrial injury on 11/29/12. He subsequently reported back and upper extremity pain. Diagnoses include cervical spondylosis without myelopathy, degeneration of cervical intervertebral disc and lumbosacral spondylosis without myelopathy. Treatments to date include physical therapy, injections and prescription pain medications. The injured worker continues to experience neck pain that radiates to the bilateral shoulders and low back pain that radiates to the bilateral lower extremities. Upon examination, there is tenderness to the left trapezius and cervical spine as well as painful range of motion and positive FABER on the right. Strength was 5/ 5. Hawkin's was positive on the left. Drop test and Impingement test were positive on the left. A request for Right sacroiliac joint injection with fluoroscopy and sedation, Physical therapy 2 x 6 weeks bilateral neck, Physical therapy 2 x 6 weeks low back and Physical therapy 2 x 6 weeks left shoulder was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right sacroiliac joint injection with fluoroscopy and sedation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), hip and pelvis.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter under SI joint injections.

Decision rationale: Based on the 12/19/14 sole progress report provided by treating physician, the patient presents with unchanged pain to back based on physical examination findings. The request is for right sacroiliac joint injection with fluoroscopy and sedation. RFA with the request not provided. Patient's diagnosis on 12/19/14 includes lumbar/lumbosacral disc degeneration, lumbar spondylosis without myelopathy, and lumbar myofascial sprain/strain. The patient ambulates with antalgic gait. EMG/NCS of the bilateral lower extremities on 02/18/14 demonstrated normal results, per 12/19/14 report. Treatment to date has included physical therapy, home exercise program and medications. Patient's medications include Ibuprofen, Vimovo, Famotidine, Benicar and Amlodipine. The patient is not working, per 12/19/14 report. ODG guidelines, Low Back Chapter under SI joint injections states: "Treatment: There is limited research suggesting therapeutic blocks offer long-term effect. There should be evidence of a trial of aggressive conservative treatment (at least six weeks of a comprehensive exercise program, local icing, mobilization/manipulation and anti-inflammatories) as well as evidence of a clinical picture that is suggestive of sacroiliac injury and/or disease prior to a first SI joint block." ODG further states that, "The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed.." "Diagnosis: Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction: Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillet's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; Thigh Thrust Test (POSH)." Criteria for the use of sacroiliac blocks: 7. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks. Treater does not discuss the request. In this case, the patient has trialed aggressive conservative treatments but continues with pain. Physical examination to the lumbar spine on 12/19/14 revealed tenderness to buttocks, sciatic notches and sacroiliac joints. Range of motion was decreased, especially on extension 10 degrees. Supine Straight leg, Flip test (Sitting SLR) and Lasegue's tests were positive on the right. However, treater has not documented more than three positive diagnostic tests to meet SI joint dysfunction criteria. SLR test is not indicative of SI joint dysfunction. ODG guidelines require 3 positive exam findings in order to proceed with SI joint injection. Therefore, the request is not medically necessary.

Physical therapy 2 x 6 weeks bilateral neck: 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: Based on the 12/19/14 sole progress report provided by treating physician, the patient presents with unchanged pain to neck based on physical examination findings. The request is for physical therapy 2 x 6 weeks bilateral neck. RFA with the request not provided. Patient's diagnosis on 12/19/14 includes cervical disc degeneration, cervical spondylosis, and cervical myofascial sprain/strain. The patient ambulates with antalgic gait. Physical examination to the cervical spine on 12/19/14 revealed tenderness to the bilateral paraspinals muscles and decreased range of motion. Positive Spurling's test. EMG/NCS of the bilateral upper extremities on 02/18/14 demonstrated "entrapment of medial nerves both wrists, moderate slowing (Carpal Tunnel Syndrome)," per 12/19/14 report. Treatment to date has included physical therapy, home exercise program and medications. Patient's medications include Ibuprofen, Vimovo, Famotidine, Benicar and Amlodipine. The patient is not working, per 12/19/14 report. MTUS Chronic Pain Management Guidelines, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." Given the patient's continued pain, a short course of physical therapy would appear to be indicated. However, treater has not provided a precise treatment history, nor documented efficacy of prior therapy. The patient is on home exercise program, and there is no explanation of why on-going supervised therapy is needed. Furthermore, the request for 12 sessions would exceed what is allowed by MTUS for the patient's condition. Therefore, the request is not medically necessary.

Physical therapy 2 x 6 week low back: 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: Based on the 12/19/14 sole progress report provided by treating physician, the patient presents with unchanged pain to back based on physical examination findings. The request is for physical therapy 2 x 6 weeks for low back. RFA with the request not provided. Patient's diagnosis on 12/19/14 includes lumbar/lumbosacral disc degeneration, lumbar spondylosis without myelopathy, and lumbar myofascial sprain/strain. The patient ambulates with antalgic gait. Physical examination to the lumbar spine on 12/19/14 revealed tenderness to buttocks, sciatic notches and sacroiliac joints. Range of motion was decreased, especially on extension 10 degrees. Supine Straight leg, Flip test (Sitting SLR) and Lasegue's tests were positive on the right. EMG/NCS of the bilateral lower extremities on 02/18/14 demonstrated normal results, per 12/19/14 report. Treatment to date has included physical therapy, home exercise program and medications. Patient's medications include Ibuprofen, Vimovo, Famotidine, Benicar and Amlodipine. The patient is not working, per 12/19/14 report. MTUS Chronic Pain Management Guidelines, pages 98, 99 has the following: "Physical Medicine:

recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Given the patient's continued pain, a short course of physical therapy would appear to be indicated. However, treater has not provided a precise treatment history, nor documented efficacy of prior therapy. The patient is on home exercise program, and there is no explanation of why on-going supervised therapy is needed. Furthermore, the request for 12 sessions would exceed what is allowed by MTUS for the patient's condition. Therefore, the request is not medically necessary.

Physical therapy 2 x 6 weeks left shoulder: 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: Based on the 12/19/14 sole progress report provided by treating physician, the patient presents with unchanged pain to left shoulder based on physical examination findings. The patient is status post left acromioplasty and distal clavicle resection, date unspecified. The request is for physical therapy 2 x 6 weeks left shoulder. RFA with the request not provided. Patient's diagnosis on 12/19/14 includes shoulder arthralgia, and shoulder impingement/bursitis. The patient ambulates with antalgic gait. Physical examination to the left shoulder on 12/19/14 revealed decreased range of motion and positive Drop arm and Impingement tests. Treatment to date has included physical therapy, shoulder injection, home exercise program and medications. Patient's medications include Ibuprofen, Vimovo, Famotidine, Benicar and Amlodipine. The patient is not working, per 12/19/14 report. MTUS Chronic Pain Management Guidelines, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Given the patient's continued pain, a short course of physical therapy would appear to be indicated. However, treater has not provided a precise treatment history, nor documented efficacy of prior therapy. The patient is on home exercise program, and there is no explanation of why on-going supervised therapy is needed. Furthermore, the request for 12 sessions would exceed what is allowed by MTUS for the patient's condition. Therefore, the request is not medically necessary.