

Case Number:	CM15-0127916		
Date Assigned:	07/20/2015	Date of Injury:	02/09/2011
Decision Date:	09/24/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/02/2015

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, Indiana, Oregon
 Certification(s)/Specialty: Orthopedic Surgery

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 (IW) is a 55-year-old female who sustained an industrial injury on 02/09/2011. Diagnoses include cervical and lumbar myofascial pain; intervertebral disc disease; trigger finger, left thumb; and status post right cubital tunnel release. Treatment to date has included medications, right ulnar nerve surgery, occupational therapy, acupuncture, chiropractic treatment and physical therapy. According to the progress notes dated 6/11/15, the IW reported low back pain radiating down both legs with numbness in the feet; medications were reportedly helpful for the pain and muscle spasms, reducing her pain from 7/10 to 4/10. Heat and stretching exercises were also helpful. On examination, spinal restrictions/subluxations were recorded at every spinal level plus the sacrum, bilateral pelvis and coccyx, as well as the bilateral shoulders and upper extremities. Tenderness was present in all these areas, with spasms documented throughout most of the posterior body and the dorsal aspects of the feet. The MRI of the cervical spine on 2/27/15 showed reversal of the cervical lordosis, degenerative disc disease; posterior disc protrusion with spinal stenosis and possible bilateral nerve root impingement of C6 and C7. A request was made for pre-operative labs/chest x-ray/EKG and post-operative physical therapy once a week for 15 weeks for the left thumb for trigger finger release; cervical epidural steroid injections; chiropractic physical rehabilitation for the cervical spine, twice a week for three weeks; and massage therapy twice a week for three weeks for the cervical and lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-operative labs/EKG/Chest x-ray: 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).

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.

Decision rationale: CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states, "These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative ECG in patients without known risk factor for coronary artery disease, regardless of age, may not be necessary. CBC is recommended for surgeries with large anticipated blood loss. Creatinine is recommended for patient with renal failure. Electrocardiography is recommended for patients undergoing high risk surgery and those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 55 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore the request is not medically necessary.

Post-operative physical therapy (left thumb) (1x15): Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines
Page(s): 22.

Decision rationale: Per the CA MTUS/Post Surgical Treatment Guidelines, page 22, 9 visits over a 3-month period is authorized. Half of the visits are initially recommended pending re-evaluation. In this case the request exceeds the initial recommended treatment number and is therefore not medically necessary.

Cervical epidural steroid injections: Upheld

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

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

Decision rationale: According to the CA MTUS/ Chronic Pain Medical Treatment Guidelines, Epidural Steroid injections page 46 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. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There must be evidence that the claimant is unresponsive to conservative treatment (exercises, physical methods, NSAIDs, and muscle relaxants). In this case the exam notes do not demonstrate a radiculopathy that is specific to a dermatome on physical exam. In addition there is lack of evidence of failure of conservative care. Therefore the request is not medically necessary.

Chiropractic physical rehabilitation (cervical, lumbar) (2x3): Upheld

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

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

Decision rationale: Per the CA MTUS/Chronic Pain Medical Treatment Guidelines, Manual therapy and manipulation, page 58, chiropractic care is recommended as an option with a trial of 6 visits over 2 weeks with evidence of objective functional improvement, with a total of up to 18 visits over 6-8 weeks. In this case, the worker had prior treatments. The number and effect are not documented. Without this information, the request is not medically necessary.

Massage therapy (cervical, lumbar) (2x3): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy.

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

Decision rationale: Per the CA MTUS/Chronic Pain Medical Treatment Guidelines, Manual therapy and manipulation, page 58, chiropractic care is recommended as an option with a trial of 6 visits over 2 weeks with evidence of objective functional improvement, with a total of up to 18 visits over 6-8 weeks. In this case, the worker had prior treatments. The number and effect are not documented. Without this information, the request is not medically necessary.