

<b>Case Number:</b>	CM15-0129569		
<b>Date Assigned:</b>	07/16/2015	<b>Date of Injury:</b>	02/24/2015
<b>Decision Date:</b>	08/11/2015	<b>UR Denial Date:</b>	06/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/06/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 60 year old female, who sustained an industrial injury on February 24, 2015. She reported an injury to her back, right shoulder and right wrist. She was diagnosed with lumbar sprain-strain, shoulder sprain-strain and radial styloid tenosynovitis. Treatment to date has included work modifications, NSAIDS, diagnostic imaging, physical therapy, heat therapy, orthotics, MRI of the lumbar spine and pain medications. Currently, the injured worker complains of irritability of the shoulder, cervical pain and lumbar pain. She reports that she cannot work as often as she would like and has a loss of function. She reports pain over the cervical spine and most significant pain in the right arm. On physical examination the injured has decreased sensation in the C6 and C7 nerve root distributions. She has positive Spurling's test on the right side. She has positive Phalen's test and Tinel's test with little decreased sensation in the median nerve distribution and C7 nerve root distribution. She has decreased sensation in the quads and tibialis anterior with 4/5 muscle strength. An MRI of the lumbar spine revealed degenerative disc disease of L4-5 and L5-S1 with severe stenosis at L4-5 and moderate stenosis of L5-S1. The diagnoses associated with the request include severe carpal tunnel syndrome and possible cervical radiculopathy. The treatment plan includes MRI of the cervical spine, MRI of the lumbar spine, bilateral lumbar epidural steroid injection, night splints, physical therapy of the lumbar and cervical spine, referral to a wrist/hand specialist and Norco.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 times a week for 6 weeks for the lumbar and cervical spine: 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): 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 the rehabilitation 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 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. (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 active treatment 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 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The goal of physical therapy is graduation to home therapy after a certain amount of recommended sessions. The request is in excess of these recommendations per the California MTUS. There is no objective reason why the patient would not be moved to home therapy after completing the recommended amount of supervised sessions In the provided clinical documentation. Therefore the request is not medically necessary.

**Bilateral lumbar epidural injections at L4-5, L5-S1: Overturned**

**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.

**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 injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The provided clinical documentation for review does meet criteria as outlined above for ESI and therefore the request is medically necessary.

**Referral to hand specialist:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 3 Initial Approaches to Treatment.

**Decision rationale:** Per the ACOEM :The health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for 1. Consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The patient upon review of the provided medical records has ongoing hand and wrist pain despite conservative therapy. The referral for a hand specialist would thus be medically necessary and approved.