MAXIMUS Federal Services

Case Number:	CM15-0142984		
Date Assigned:	08/03/2015	Date of Injury:	04/23/2009
Decision Date:	10/08/2015	UR Denial Date:	07/20/2015
Priority:	Standard	Application Received:	07/23/2015

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 56-year-old female who sustained an industrial injury on 04/23/2009. Mechanism of injury occurred during assault training, injuring her neck, upper and lower back, right shoulder-upper arm and knee. Diagnoses include strain of the S1 ligament, rotator cuff syndrome, bursitis, labral tear, subluxation shoulder, De Quevain's tenosynovitis, carpal tunnel syndrome, and ganglion but otherwise specified, tear of the wrist, cervical disc degeneration, cervicobrachial syndrome. Treatment to date has included diagnostic studies, medications, acupuncture, massage, and Functional restoration program. On 06/30/2015 a Magnetic Resonance Imaging of the cervical spine revealed C5-C6-2mm disc osteophyte complex with mild central canal narrowing at the disc space level. There is no cord compression and the neural foraminal are patent. A Magnetic Resonance Imaging of the right hand done on 09-03-2014 showed questioned minor third MCP joint capsulitis. On 07-17-2014 a Magnetic Resonance Imaging of the right wrist showed a partial tear with marked thinning of eh radial aspect of the triangular fibrocartilage with a small distal radioulnar joint effusion. The ulnar attachment of the triangular fibrocartilage has with a small distal radioulnar joint effusion. The ulnar attachment of the triangular fibrocartilage complex is degenerative. There is a 4mm ganglion cyst along the volar component of the scapholunate ligament. On 06-30-2014, a Magnetic Resonance Imaging of the right shoulder revealed moderate advanced acromioclavicular joint arthrosis with subchondral changes. There is a lateral down sloping acromion narrow at the lateral supraspinatus outlet; mild top moderate rotator cuff tendinosis, there is no rotator cuff tear; chronic SLAP tear with blunted morphology of the superior and posterosuperior labrum. X rays

of the lumbar spine show L4-L5 Grade 1 anterolisthesis and mild degenerative disc disease at L4-L5. A physician progress note dated 07-08-2015 documents the injured worker complains of back, right knee and neck pain. She rates her pain at its worst as 10 out of 10 in the last week. At its best, her pain was rated a 6 out of 10, and on average, her pain was 7 out of 10. The pain is constant. She has mild knee swelling with crepitus in both knees. Trigger points are palpated in the lower trapezius, gluteus maximus, and gluteus medius and quadratus lumborum bilaterally. She has pain-limited range of motion of the shoulders and elbow flexion. There is paresthesias to light touch noted in the lateral right leg. McMurray's test is positive in the left knee and patellar compresson is positive on the left and positive J sign on the left. The treatment plan includes DME purchase-Theracane quantity 1.00, DME purchase-PhysioBall 85cm-95cm quantity 1.00, DME purchase-SI Joint Belt quantity 1.00, and Hand ortho consult quantity 1.00. Treatment requested is for Acupuncture quantity 12.00, CESI quantity1.00, cervical facet block quantity 1.00, cervical nerve block quantity 1.00, Hand ortho consult quantity 1.00, L3-S1 epidural steroid injection quantity 1.00, and L3-S1 facet block quantity 1.00.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture quantity 12.00: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The patient presents with back, right knee, and neck pain. The request is for ACUPUNCTURE QUANTITY 12.00. The Request for Authorization is dated 07/13/15. MRI of the lumbar spine, 04/03/15, shows marked facet arthropathy with capsulitis and ostieitis and early facet gapping at L3-4, small protrusion and noncritical moderate narrowing of the neural foraminal outlets; facet arthrosis and hypertrophy with lesser inflammatory response at L4-5, with associated degenerative-type anterolisthesis and left eccentric protrusion with annular fissure; there is moderate neural foraminal stenosis up to down direction, greater left than right. MRI of the cervical spine, 06/30/15, shows at C5-C6, 2 mm disc osteophyte complex with mild central canal narrowing at the disc space level. There is no cord compression. The neural foramina are patent. MRI of the right hand, 09/03/14, questioned minor third MCP joint capsulitis; no apparent structural defect. Physical examination reveals trigger points palpated in the lower trapezius, gluteus maximus, gluteus medius, and quadratus lumborum bilaterally. Pain limited range of motion of the shoulders and elbow flexion. Paresthesias to light touch noted in the lateral right leg. Per progress report dated 03/05/15, the patient is temporarily very disabled. MTUS, Acupuncture Medical Treatment Section, pg. 13 of 127 states: " (i) Time to produce functional improvement: 3 to 6 treatments (ii) Frequency: 1 to 3 times per week (iii) Optimum duration: 1 to 2 months. (D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e)." Per progress report dated 07/02/15, treater's reason for the request is "to reduce the patient's ongoing symptoms of functional limitations despite conservative treatment program." Review of provided medical records show at least 10 prior treatments of Acupuncture. In this case, the patient continues with ongoing neck, right knee, and back pain. MTUS supports extended treatments with documented

functional improvement with Acupuncture. However, treater does not provide discussion or documentation regarding functional improvements with prior Acupuncture treatments. Additionally, the request for 12 additional treatments of Acupuncture would exceed what is recommended by MTUS guidelines. Therefore, the request IS NOT medically necessary.

Hand ortho consult quantity 1.00: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ACOEM, Chapter 7, page 127.

Decision rationale: The patient presents with back, right knee, and neck pain. The request is for HAND ORTHO CONSULT QUANTITY 1.00. The Request for Authorization is dated 07/13/15. MRI of the lumbar spine, 04/03/15, shows marked facet arthropathy with capsulitis and ostieitis and early facet gapping at L3-4, small protrusion and noncritical moderate narrowing of the neural foraminal outlets; facet arthrosis and hypertrophy with lesser inflammatory response at L4-5, with associated degenerative-type anterolisthesis and left eccentric protrusion with annular fissure; there is moderate neural foraminal stenosis up to down direction, greater left than right. MRI of the cervical spine, 06/30/15, shows at C5-C6, 2 mm disc osteophyte complex with mild central canal narrowing at the disc space level. There is no cord compression. The neural foramina are patent. MRI of the right hand, 09/03/14, questioned minor third MCP joint capsulitis; no apparent structural defect. Physical examination reveals trigger points palpated in the lower trapezius, gluteus maximus, gluteus medius, and quadratus lumborum bilaterally. Pain limited range of motion of the shoulders and elbow flexion. Paresthesias to light touch noted in the lateral right leg. Per progress report dated 03/05/15, the patient is temporarily very disabled. ACOEM, Chapter 7, page 127 has the following: "The occupational health practitioner may refer to other specialists 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." Treater does not discuss the request. In this case, it would appear that the current treater feels uncomfortable with the patient's medical issues and has requested a Hand Ortho Consult. Patient's diagnoses include de Quevain's tenosynovitis, carpal tunnel syndrome, ganglion, and tear of wrist. Given the patient's condition, the request for a Hand Ortho Consult appears reasonable. Therefore, the request IS medically necessary.

CESI quantity1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The patient presents with back, right knee, and neck pain. The request is for CESI QUANTITY 1.00. The Request for Authorization is dated 07/13/15. MRI of the lumbar spine, 04/03/15, shows marked facet arthropathy with capsulitis and ostieitis and early facet gapping at L3-4, small protrusion and noncritical moderate narrowing of the neural foraminal outlets; facet arthrosis and hypertrophy with lesser inflammatory response at L4-5, with associated degenerative-type anterolisthesis and left eccentric protrusion with annular fissure; there is moderate neural foraminal stenosis up to down direction, greater left than right. MRI of the cervical spine, 06/30/15, shows at C5-C6, 2 mm disc osteophyte complex with mild central canal narrowing at the disc space level. There is no cord compression. The neural foramina are patent. MRI of the right hand, 09/03/14, questioned minor third MCP joint capsulitis; no apparent structural defect. Physical examination reveals trigger points palpated in the lower trapezius, gluteus maximus, gluteus medius, and quadratus lumborum bilaterally. Pain limited range of motion of the shoulders and elbow flexion. Paresthesias to light touch noted in the lateral right leg. Per progress report dated 03/05/15, the patient is temporarily very disabled. MTUS has the following regarding ESI's, under its Chronic pain Section, Page 46, 47: "Criteria for the use of Epidural steroid injections: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3. Injections should be performed using fluoroscopy (live x-ray) for guidance. 8) Current research does not support "series-of-three" injections in either the diagnostic or the therapeutic phase. We recommend no more than 2 ESI injections." 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. Per progress report dated 07/02/15, the request is for cervical epidural steroid injection at level C5 and C6 on the right side as well as lumbar epidural steroid injection at L3-L4 for a probable facet block. MTUS requires documentation of radiculopathy by physical examination and corroborated by imaging studies. However, treater does not provide any physical exam findings of the cervical spine to determine radicular symptoms. MRI of the cervical spine shows at C5-C6, 2 mm disc osteophyte complex with mild central canal narrowing at the disc space level. There is no cord compression. The neural foramina are patent. It appears the imaging studies do not show strong evidence of radiculopathy. In this case, radiculopathy is not documented with lack of dermatomal distribution of pain along with physical examination findings corroborated by MRI findings. Therefore, the request IS NOT medically necessary.

Cervical facet block quantity 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Chapter, under Facet joint diagnostic blocks.

Decision rationale: The patient presents with back, right knee, and neck pain. The request is for CERVICAL FACET BLOCK QUANTITY 1.00. The Request for Authorization is dated 07/13/15. MRI of the lumbar spine, 04/03/15, shows marked facet arthropathy with capsulitis

and ostieitis and early facet gapping at L3-4, small protrusion and noncritical moderate narrowing of the neural foraminal outlets; facet arthrosis and hypertrophy with lesser inflammatory response at L4-5, with associated degenerative-type anterolisthesis and left eccentric protrusion with annular fissure; there is moderate neural foraminal stenosis up to down direction, greater left than right. MRI of the cervical spine, 06/30/15, shows at C5-C6, 2 mm disc osteophyte complex with mild central canal narrowing at the disc space level. There is no cord compression. The neural foramina are patent. MRI of the right hand, 09/03/14, questioned minor third MCP joint capsulitis; no apparent structural defect. Physical examination reveals trigger points palpated in the lower trapezius, gluteus maximus, gluteus medius, and quadratus lumborum bilaterally. Pain limited range of motion of the shoulders and elbow flexion. Paresthesias to light touch noted in the lateral right leg. Per progress report dated 03/05/15, the patient is temporarily very disabled. ODG-TWC, Neck and Upper Back (Acute & Chronic) Chapter, under Facet joint diagnostic blocks states: "Recommended prior to facetneurotomy (a procedure that is considered "under study"). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Criteria for the use of diagnostic blocks for facet nerve pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine. 2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 joint levels are injected in one session (see above for medial branch block levels). For facet joint pain signs and symptoms, the ODG guidelines state that physical examination findings are generally described as: "1) axial pain, either with no radiation or severely past the shoulders; 2) tenderness to palpation in the paravertebral areas, over the facet region; 3) decreased range of motion, particularly with extension and rotation; and 4) absence of radicular and/or neurologic findings." Per progress report dated 07/02/15, the request is for cervical epidural steroid injection at level C5 and C6 on the right side as well as lumbar epidural steroid injection at L3-L4 for a probable facet block. The patient has trialed conservative treatments but continues with neck pain. However, treater does not provide any physical exam findings of the cervical spine to determine if the pain is non-radicular with no neurologic findings. Given the lack of documentation, a determination for a Cervical Facet Block cannot be made. Therefore, the request IS NOT medically necessary.

L3-S1 facet block quantity 1.00: 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 - Lumbar & Thoracic (Acute & Chronic) Chapter, under Facet joint diagnostic block (injections).

Decision rationale: The patient presents with back, right knee, and neck pain. The request is for L3-S1 FACET BLOCK QUANTITY 1.00. The Request for Authorization is dated 07/13/15.

MRI of the lumbar spine, 04/03/15, shows marked facet arthropathy with capsulitis and ostieitis and early facet gapping at L3-4, small protrusion and noncritical moderate narrowing of the neural foraminal outlets; facet arthrosis and hypertrophy with lesser inflammatory response at L4-5, with associated degenerative-type anterolisthesis and left eccentric protrusion with annular fissure; there is moderate neural foraminal stenosis up to down direction, greater left than right. MRI of the cervical spine, 06/30/15, shows at C5-C6, 2 mm disc osteophyte complex with mild central canal narrowing at the disc space level. There is no cord compression. The neural foramina are patent. MRI of the right hand, 09/03/14, questioned minor third MCP joint capsulitis; no apparent structural defect. Physical examination reveals trigger points palpated in the lower trapezius, gluteus maximus, gluteus medius, and quadratus lumborum bilaterally. Pain limited range of motion of the shoulders and elbow flexion. Paresthesias to light touch noted in the lateral right leg. Per progress report dated 03/05/15, the patient is temporarily totally disabled.ODG Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, under Facet joint diagnostic block (injections) Section states, "Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy. Criteria for the use of diagnostic blocks for facet "mediated" pain: 1. One set of diagnostic medial branch blocks is required with a response of "70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels)." Per progress report dated 07/02/15, the request is for cervical epidural steroid injection at level C5 and C6 on the right side as well as lumbar epidural steroid injection at L3-L4 for a probable facet block. ODG guidelines limit Facet Blocks for patients with non-radicular low-back pain. The patient has trialed conservative treatments but continues with back pain. However, treater does not provide any physical exam findings of the lumbar spine to determine if the pain is non-radicular with no neurologic findings. Given the lack of documentation, a determination for a L3-S1 Facet Block cannot be made. Therefore, the request IS NOT medically necessary.

Cervical nerve block quantity 1.00: 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: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The patient presents with back, right knee, and neck pain. The request is for CERVICAL NERVE BLOCK QUANTITY 1.00. The Request for Authorization is dated 07/13/15. MRI of the lumbar spine, 04/03/15, shows marked facet arthropathy with capsulitis and ostieitis and early facet gapping at L3-4, small protrusion and noncritical moderate narrowing of the neural foraminal outlets; facet arthrosis and hypertrophy with lesser inflammatory response at L4-5, with associated degenerative-type anterolisthesis and left eccentric protrusion with annular fissure; there is moderate neural foraminal stenosis up to down direction, greater left than right. MRI of the cervical spine, 06/30/15, shows at C5-C6, 2 mm disc osteophyte complex with mild central canal narrowing at the disc space level. There is no

cord compression. The neural foramina are patent. MRI of the right hand, 09/03/14, questioned minor third MCP joint capsulitis; no apparent structural defect. Physical examination reveals trigger points palpated in the lower trapezius, gluteus maximus, gluteus medius, and quadratus lumborum bilaterally. Pain limited range of motion of the shoulders and elbow flexion. Paresthesias to light touch noted in the lateral right leg. Per progress report dated 03/05/15, the patient is temporarily very disabled. MTUS has the following regarding ESI's, under its Chronic pain Section, Page 46, 47: "Criteria for the use of Epidural steroid injections: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3. Injections should be performed using fluoroscopy (live x-ray) for guidance. 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." 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. Per progress report dated 07/02/15, the request is for cervical epidural steroid injection at level C5 and C6 on the right side as well as lumbar epidural steroid injection at L3- L4 for a probable facet block. MTUS requires documentation of radiculopathy by physical examination and corroborated by imaging studies. However, treater does not provide any physical exam findings of the cervical spine to determine radicular symptoms. MRI of the cervical spine shows at C5-C6, 2 mm disc osteophyte complex with mild central canal narrowing at the disc space level. There is no cord compression. The neural foramina are patent. It appears the imaging studies do not show strong evidence of radiculopathy. In this case, radiculopathy is not documented with lack of dermatomal distribution of pain along with physical examination findings corroborated by MRI findings. Therefore, the request IS NOT medically necessary.

L3-S1 epidural steroid injection quantity 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The patient presents with back, right knee, and neck pain. The request is for L3-S1 EPIDURAL STEROID INJECTION QUANTITY 1.00. The Request for Authorization is dated 07/13/15. MRI of the lumbar spine, 04/03/15, shows marked facet arthropathy with capsulitis and ostieitis and early facet gapping at L3-4, small protrusion and noncritical moderate narrowing of the neural foraminal outlets; facet arthrosis and hypertrophy with lesser inflammatory response at L4-5, with associated degenerative-type anterolisthesis and left eccentric protrusion with annular fissure; there is moderate neural foraminal stenosis up to down direction, greater left than right. MRI of the cervical spine, 06/30/15, shows at C5-C6, 2 mm disc osteophyte complex with mild central canal narrowing at the disc space level. There is no cord compression. The neural foramina are patent. MRI of the right hand, 09/03/14, questioned minor third MCP joint capsulitis; no apparent structural defect. Physical examination reveals trigger points palpated in the lower trapezius, gluteus maximus, gluteus medius, and

quadratus lumborum bilaterally. Pain limited range of motion of the shoulders and elbow flexion. Paresthesias to light touch noted in the lateral right leg. Per progress report dated 03/05/15, the patient is temporarily very disabled. MTUS has the following regarding ESI?s, under its Chronic pain Section, Page 46, 47: "Criteria for the use of Epidural steroid injections: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3. Injections should be performed using fluoroscopy (live x-ray) for guidance. 8) Current research does not support "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections." 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. Per progress report dated 07/02/15, the request is for cervical epidural steroid injection at level C5 and C6 on the right side as well as lumbar epidural steroid injection at L3-L4 for a probable facet block. MTUS requires documentation of radiculopathy by physical examination and corroborated by imaging studies. However, treater does not provide any physical exam findings of the lumbar spine to determine radicular symptoms. MRI of the lumbar spine, shows marked facet arthropathy with capsulitis and ostieitis and early facet gapping at L3-4, small protrusion and noncritical moderate narrowing of the neural foraminal outlets; facet arthrosis and hypertrophy with lesser inflammatory response at L4-5, with associated degenerative-type anterolisthesis and left eccentric protrusion with annular fissure; there is moderate neural foraminal stenosis up to down direction, greater left than right. In this case, radiculopathy is not documented with lack of dermatomal distribution of pain along with physical examination findings corroborated by MRI findings. Therefore, the request IS NOT medically necessary.