

<b>Case Number:</b>	CM15-0028650		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	12/10/2013
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	02/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/17/2015

### 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 49 year old male, who sustained an industrial injury on December 10, 2013. He has reported constant sharp pain in the right knee, right shoulder and wrist, pain in the neck and low back pain associated with radiation of pain, stiffness and weakness. The diagnoses have included cervical spine strain/sprain, sciatica, lumbar spine sprain/strain and right shoulder sprain. Treatment to date has included Radiographic imaging, diagnostic studies, conservative therapies, pain medications and work restrictions. Currently, the IW complains of constant sharp pain in the right knee, right shoulder and wrist, pain in the neck and low back pain associated with radiation of pain, stiffness and weakness. The injured worker reported an industrial injury in 2013, resulting in a tear to the right knee and constant pain as previously noted. He was treated conservatively without resolution of the pain. Magnetic resonance imaging on June 27, 2014, revealed lumbar spondylosis with disc protrusions. Evaluation on July 30, 2014, revealed continued pain. Pain medications were renewed, a knee brace was ordered and it was noted he was waiting to undergo surgical intervention of the right knee. Evaluation on December 27, 2014, revealed continued complaints. It was noted he had completed some physical therapy and the remainder of the treatments rendered were not legible. Evaluation on February 12, 2015, revealed continued pain. On February 12, 2015, Utilization Review non-certified a request for physical therapy, 2 times per week for 3 weeks of the lumbar spine, right shoulder and right wrist, noting the MTUS, ACOEM Guidelines, (or ODG) was cited. On February 27, 2015, the injured worker submitted an application for IMR for review of requested physical therapy 2 times per week for 3 weeks of the lumbar spine, right shoulder and right wrist.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Lumbar epidural steroid injection L4-L5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines Epidural Steroid Injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46.

**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 patient has the documentation of low back pain and subjective radiculopathy symptoms; however there is no documentation of radiculopathy on the physical exam. For these reasons criteria as set forth above per the California MTUS have not been met. The request is not certified.

### **Physical therapy 2xwk x 3wks to the lumbar spine, right shoulder and right wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers Compensation, On-line Edition, Chapter: Low Back; Forearm, Wrist and Hand; and Physical Therapy.

**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 requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. The patient has already completed an unspecified amount of physical therapy previously. There is no explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. In the absence of such documentation, the request cannot be certified.