

Case Number:	CM15-0075516		
Date Assigned:	04/27/2015	Date of Injury:	01/06/2010
Decision Date:	07/01/2015	UR Denial Date:	04/01/2015
Priority:	Standard	Application Received:	04/20/2015

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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

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 50 year old female, who sustained an industrial injury on 1/06/2010. She reported developing neck and thoracic back pain from repetitive lifting. Diagnoses include lumbar disc displacement, spondylosis, cervicgia, myalgia and myositis, chronic pain syndrome and pain in joint of upper arm. Treatments to date include activity modification, medication therapy, acupuncture treatments, and therapeutic injections. Currently, she complained of ongoing neck and back pain. On 3/24/15, the physical examination documented multiple areas of tenderness with radiation. There was pain with range of motion of the neck and thoracic spine. The plan of care included acupuncture treatments and aquatic physical therapy and requested for authorizations for a cervical and thoracic MRI, transforaminal epidural steroid injection to L2-3 and L3-4, and Voltaren Gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture x 6 thoracolumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Acupuncture.

Decision rationale: Regarding the request for additional acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as either a clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment. A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, it appears the patient has undergone acupuncture previously and there is no documentation of objective functional improvement from the therapy already provided. As such, the currently requested acupuncture is not medically necessary.

MRI without contrast, thoracic: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176-177.

Decision rationale: Regarding the request for thoracic MRI, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Guidelines also recommend MRI after 3 months of conservative treatment. Within the documentation available for review, there is no indication of any red flag diagnoses. Additionally there is no documentation of neurologic deficit thought to be coming from the thoracic spine. In the absence of such documentation, the requested thoracic MRI is not medically necessary.

Left side L2-L3, L3-L4 transforaminal epidural steroid injection: 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 9792.20-9792.26 Page(s): 46 of 127.

Decision rationale: Regarding the request for repeat left lumbar transforaminal epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Guidelines recommend that no more than one interlaminar level, or two transforaminal levels,

should be injected at one session. Regarding repeat epidural injections, guidelines state that 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. Within the documentation available for review, there is indication of at least 50% pain relief but without the associated reduction of medication use for 6 to 8 weeks as well as functional improvement from previous epidural injections. Furthermore, there are no imaging or electrodiagnostic studies confirming a diagnosis of radiculopathy. As such, the currently requested repeat left lumbar transforaminal epidural steroid injection is not medically necessary.

Pool therapy x 12 thoracic 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 9792.20 - 9792.26 Page(s): 22, 98-99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for aquatic therapy, Chronic Pain Treatment Guidelines state that aquatic therapy is recommended as an optional form of exercise therapy where available as an alternative to land-based physical therapy. They go on to state that it is specifically recommended whenever reduced weight bearing is desirable, for example extreme obesity. Guidelines go on to state that for the recommendation on the number of supervised visits, see physical therapy guidelines. ODG recommends a maximum of 10 visits of physical therapy over 8 weeks following a 6 visit clinical trial, in the treatment of mid back pain. Within the documentation available for review, there is no statement indicating why the patient would require reduced weight-bearing exercise. Additionally, reduced weight-bearing exercise is usually recommended for knee or low back problems, but not generally utilized for mid back complaints. The requesting physician has not stated why aquatic therapy would be indicated for this patient's current mid back complaints. Additionally, the number of treatments requested (12 sessions) exceeds the initial 6 visit trial recommended by ODG. In the absence of clarity regarding those issues, the currently requested aquatic therapy is not medically necessary.