

Case Number:	CM15-0094002		
Date Assigned:	05/22/2015	Date of Injury:	06/08/2009
Decision Date:	09/24/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	05/15/2015

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 (IW) is a 48-year-old female who sustained an industrial injury on 06/08/2009. She reported bilateral shoulder pain, pain in the neck, and pain in the back. The injured worker was diagnosed as having lumbago, cervicobrachial syndrome, and pain in joint, shoulder; other chronic pain. Treatment to date has included right and left shoulder arthroscopies, left knee surgery times two, discectomy and fusion times two (C6-7 and C5-6), physical therapy, and medications. Currently, the injured worker complains of ongoing pain in the back, neck and shoulder. She is alert and conversant with no apparent negative effects from medications. The sub occipital area and trapezius are tender. There is no change in gait. The worker takes Ibuprofen, Protonix, Flexeril, and Fioricet and has been using Thermacare patches. The plan is for continuation of medications and keep worker aware of the status of submitted requests. Requests for authorization have been submitted for a treatment plan that includes Physical therapy evaluation for the cervical spine, Physical therapy 2 x 6 for the cervical spine, Facet block at L4-5 and L5-S1, Epidural steroid injection at L4-5 and L5-S1, NCS of the upper extremities #2, EMG of the upper extremities, and Pain management evaluation of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy Evaluation for the Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7 Independent Medical Examinations and Consultations, page 127.

Decision rationale: American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ACOEM guidelines, chapter 7, page 127 state that 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. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. MTUS Guidelines pages 98 to 99 state that for patients with "myalgia and myositis, 9 to 10 sessions over 8 weeks are allowed, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits over 4 weeks are allowed." In this case, the patient has had physical therapy in the past. As per progress report dated 02/24/15, the patient completed 12 sessions of physical therapy, and also underwent the "maximum allowed" sessions of PT after the cervical fusion. The treater is now requesting for 12 additional sessions but does not explain why the patient needs a repeat therapy evaluation. The treater does not seem to address any need for repeat evaluation hence the request is not medically necessary.

Physical Therapy for the Cervical Spine (12-sessions, 2 times a week for 6-weeks): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: MTUS Chronic Pain Management Guidelines, pages 98, 99 under Physical Medicine section has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine". MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. In this case, the patient has had physical therapy in the past. As per progress report dated 02/24/15, the patient completed 12 sessions of physical therapy, and also underwent the "maximum allowed" sessions of PT after the cervical fusion. The treater, however, does not document efficacy of prior therapy in terms of reduction in pain and improvement in function. Additionally, MTUS only allows for 8-10 sessions in non-operative cases and the treater's request for 12 sessions exceeds that request. Hence, it is not medically necessary.

Facet Block at L4-5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12 low back complaints, under "Physical Methods", pages 300 states Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. " ODG Low Back Chapter, under Facet Joint Diagnostic Blocks states: "Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment - a procedure that is still considered under study". Diagnostic blocks may be 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. Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. Criteria for the use of diagnostic blocks for facet "mediated" pain: 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level." In this case, a review of the reports indicates that the patient has not undergone this procedure in the past. Additionally, none of the reports discuss the request. Progress report dated 04/06/15 indicates that the patient suffers from a low back pain but does not indicate a radicular component nor the location of pain raise a suspicion that the pain may be facet joint mediated. Facet joint syndrome typically results in lateralized pain with tenderness and pain over the paravertebral facet joints. There is a prior progress report dated 02/24/15, which states that the patient has lower back pain that radiates to bilateral legs with numbness in bilateral feet. ODG typically does not support facet joint evaluations for patients with clear radicular symptoms. The treater is also requesting ESI's presumably to treat the patient's radicular symptoms. The request is not medically necessary.

Epidural Steroid Injection at L4-5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of epidural steroid injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46, 47.

Decision rationale: The MTUS Guidelines has the following regarding ESI under Epidural Steroid Injections (ESIs) section page 46 and 47, "Recommended as an option for treatment of radicular pain." MTUS has the following criteria regarding ESI's, under its chronic pain section: Page 46, 47 "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." For repeat ESI, MTUS states, "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." ODG guidelines, chapter 'Low Back -Lumbar & Thoracic (Acute & Chronic)' and topic 'Epidural steroid injections (ESIs), therapeutic', state that "At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections". In this case, a review of the reports indicates that the patient has not undergone this procedure in the past. In fact, in progress report dated 04/06/15, prior ESI request was denied. Progress report dated 04/06/15 indicates that the patient suffers from a low back pain but does not indicate a radicular component. However, a prior progress report dated 02/24/15 states that the patient has lower back pain that radiates to bilateral legs with numbness in bilateral feet. None of the reports document the results of the SLR. In progress report dated 02/24/15, the treater states that the patient has had a lumbar MRI in November, 2014. However, the results of this study are not available for review. MTUS requires clear indication of radiculopathy during physical examination along with corroborating diagnostic evidence for ESI. Hence, the request is not medically necessary.

NCS of the Upper Extremities, #2: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, Neck and Upper Back Complaints, Special Studies and Diagnostic and Treatment Considerations, page 178 states: "Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks". MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, Forearm, Wrist, and Hand Complaints, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist". In this case, the progress reports do not document prior NCS of the upper extremities. None of the progress reports discuss the request as well. The patient does suffer from neck pain and bilateral shoulder pain with numbness in bilateral wrists and hands, as per progress report dated 02/24/15. The symptoms persist in spite of undergoing surgery and physical therapy and using medications. NCS may help diagnose the patient's condition accurately and differentiate between radiculopathy and CTS. Hence, the request is medically necessary.

EMG of the Upper Extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, Neck and Upper Back Complaints, Special Studies and Diagnostic and Treatment Considerations, page 178 states: "Electromyography (EMG), and nerve conduction velocities (NCV), including H- reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks". MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, Forearm, Wrist, and Hand Complaints, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist". In this case, the progress reports do not document prior EMG of the upper extremities. None of the progress reports discuss the request as well. The patient does suffer from neck pain and bilateral shoulder pain with numbness in bilateral wrists and hands, as per progress report dated 02/24/15. The symptoms persist in spite of undergoing surgery and physical therapy and using medications. NCS may help diagnose the patient's condition accurately and differentiate between radiculopathy and CTS. Hence, the request is medically necessary.