

<b>Case Number:</b>	CM15-0099787		
<b>Date Assigned:</b>	06/02/2015	<b>Date of Injury:</b>	02/23/2011
<b>Decision Date:</b>	06/30/2015	<b>UR Denial Date:</b>	04/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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: Maryland

Certification(s)/Specialty: Internal Medicine, Rheumatology

### 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 male who sustained an industrial injury on February 23, 2011. He has reported injury to bilateral shoulders and has been diagnosed with lower back pain, neck pain, lumbar strain, impingement of the left shoulder, and complete tear of rotator cuff, right. Treatment has included surgery, medical imaging, medications, and physical therapy. Right shoulder had flexion at 160 degrees, abduction 150 degrees, external rotation at 70 degrees, internal rotation at 70 degrees, abduction at 30 degrees, and extension at 50 degrees. The left shoulder showed flexion at 160 degrees, abduction at 160 degrees, external rotation at 80 degrees, internal rotation at 70, abduction at 30 degrees, and extension at 50 degrees. Neer's test was mildly painful on the right. Elbow flexion test was positive on the right. O'Brien's test was mildly painful on the left. The treatment request included a lumbosacral epidural steroid injection x 2 and postoperative physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar spine ESFI at L4-S1 x2: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

Decision based on Non-MTUS Citation Physicians/ASIPP (Pain - 1/05) and on the Non-MTUS Guidelines of the North American Spine Society/NASS and on the Non-MTUS Practice Parameters of the IMC of California and on the Non-MTUS Official Disability Guidelines (ODG), Lumbar ESO.

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

**Decision rationale:** This 56 year old male has complained of shoulder pain and low back pain since date of injury 2/23/11. He has been treated with surgery, physical therapy and medications. The current request is for lumbar spine ESFI at L4-S1 X 2. Per the MTUS guidelines cited above epidural corticosteroid injections are recommended as an option for the treatment of radicular pain when the specific following criteria are met: 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 available medical records do not include documentation that criteria (1) above has been met. Specifically, the available provider notes do not document evidence of radiculopathy by physical examination. On the basis of the MTUS guidelines, a lumbar spine ESFI at L4-S1 x 2 is not indicated as medically necessary.

**Post-operative physical therapy x 12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy Guidelines.

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

**Decision rationale:** This 56 year old male has complained of shoulder pain and low back pain since date of injury 2/23/11. He has been treated with surgery, physical therapy and medications. The current request is for post-operative physical therapy x 12. Per the MTUS guidelines cited above in the section Physical Medicine/ therapy, patients should be instructed and expected to continue active therapy at home as an extension of the initial treatment process in order to maintain improvements gained in physical therapy. The MTUS recommendations for PT state for the passive (out of home) PT process, 8-10 visits over the course of 4 weeks are indicated for a diagnosis of neuralgia, neuritis and/or radiculitis, as in this case. The medical necessity for continued passive physical therapy beyond the recommended number of sessions is not

documented. as there is no evidence of a recent flare, re-injury or progression of symptoms or physical exam findings to continue PT as requested. On the basis of the available medical records and per the MTUS guidelines cited above, post-operative physical therapy x 12 is not indicated as medically necessary.