
Notice of Independent Medical Review Determination

Dated: 11/12/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/9/2013

3/23/2010

7/25/2013

CM13-0003477

- 1) MAXIMUS Federal Services, Inc. has determined the request for **twelve physical therapy sessions for right shoulder (two times a week for six weeks) is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a **cervical epidural steroid injection at C4 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a **cervical epidural steroid injection at C5 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for a **cervical myelography is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for a **cervical epidurography is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/31/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **twelve physical therapy sessions for right shoulder (two times a week for six weeks) is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a **cervical epidural steroid injection at C4 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a **cervical epidural steroid injection at C5 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for a **cervical myelography is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for a **cervical epidurography is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent medical doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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 treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 9, 2013:

According to the clinical documentation, the patient is a 48-year old individual who sustained an injury on 3/23/10 from a motor vehicle accident. According to the Visit Note dated 6/21/13 by [REDACTED] the patient presented with chronic back, knee, shoulder and neck pain. The patient reported that neck pain continued to radiate into the right upper extremity into the right thumb and fourth and fifth digits associated with numbness and tingling. The patient also reported right shoulder pain. The patient stated that Venlafaxine resulted to anxiety and diarrhea and does not wish to be on this medication or on any antidepressants at this time. The patient continued to feel depressed but denied suicidal thoughts. Patient's gait was antalgic and ambulated with assistance of a single-point cane. Examination of the neck revealed tenderness to palpation at the right sided cervical paraspinal muscles with muscle tension extension into the right upper trapezius muscle. Spurling sign was positive with pain radiating into the right shoulder and upper extremity. Sensations were decreased to light touch at the right upper extremity and a C4 and C5 dermatomal distribution. Motor strength was difficult to assess due to right upper extremity and right shoulder pain. Right hand grip was decreased compared to left hand. Examination of the right shoulder revealed tenderness to palpation over the entire right shoulder joint but especially posteriorly. Range of motion on right shoulder was difficult to ascertain secondary to guarding and pain. Abduction and flexion was decreased by 70%. Impingement sign was positive at the right shoulder. Past surgeries included a right knee arthroscopic surgery on 10/4/2010 and L5-S1 right hemilaminotomy, medial facetectomy, discectomy and foraminotomy for decompression of the L5 nerve root on 7/16/2012. Despite these, the patient continued to complain of low back pain. Other therapies and/or interventions included chiropractic treatment, transcutaneous electrical nerve stimulation (TENS) unit, and physical therapy (completed visits to date was not documented) without significant improvement. Patient also received lumbar epidural steroid injections (levels were not documented) and sacroiliac injections without benefit. Magnetic resonance imaging (MRI) of the lumbar spine dated 1/11/2012, reviewed by [REDACTED] MD [Utilization Review Treatment Appeal dated 1/14/2013], documented findings of: (1) no significant change since the prior examination; (2) disc degeneration at L5-S1 with a broad-based, right foraminal disc protrusion and associated degenerative spurring. Moderate right foraminal narrowing is unchanged, along with mild right lateral recess narrowing. MRI on the cervical spine dated 6/5/13 documented disc protrusion at C4-C5 causing moderate proximal right foraminal stenosis and mild central canal stenosis, C6-C7 bulge causing moderate to severe bilateral foraminal stenosis and thecal sac mildly effaced and C5-C6 disc protrusion with mild-to-moderate central canal stenosis. The patient had positive Spurling and decreased sensation in a C4 and C5 dermatomal distribution. There were no acromial joint arthrosis and mild fluid in the subacromial subdeltoid bursa noted. The provider believed that there was inflammation at the right shoulder and required cortisone injection and will be requested. The patient required physical therapy after the injection to increase range of motion. There was no objective interpretation of the MRI of right shoulder results attached in the medical report submitted. Electromyography (EMG) of the lower extremities dated 8/15/2011, reviewed by [REDACTED] MD [Utilization Review Treatment Appeal dated 1/14/2013], documented: (1) this is an abnormal electrodiagnostic study; (2) there were findings suggestive of a right L4/5 lumbar radiculopathy; the patient appeared to be in significant pain and acromial joint arthrosis and mild fluid in the subacromial subdeltoid bursa noted. The provider believed that there was inflammation at the right shoulder and required cortisone injection and will be requested. The patient required physical therapy after the injection to increase range of motion. There was no objective interpretation of the MRI of right shoulder results attached in the medical report submitted. Electromyography (EMG) of the lower extremities dated 8/15/2011, reviewed by [REDACTED] MD [Utilization Review Treatment Appeal dated 1/14/2013], documented: (1) this is an abnormal electrodiagnostic study; (2) there were findings suggestive of a right L4/5 lumbar radiculopathy; the patient appeared to be in significant pain and

had difficulty providing good voluntary muscle contraction for measuring motor unit morphology and recruitment patterns in the right lower extremity; there were brillations in the right lumbar paraspinal muscles and findings of chronic denervation changes in a single muscle in the right L4/5 myotome to suggest the diagnosis of chronic right L4/5 myotome to suggest the diagnosis of chronic right L4/5 lumbar radiculopathy without acute axonal denervation; findings were consistent with the neurological examination; right S1 radiculopathy was less likely as H-reflex studies were symmetric and within normal clinical correlation with diagnostic imaging is recommended; (3) there was no electrodiagnostic evidence of focal neuropathy or polyneuropathy. There was no objective interpretation of the EMG result attached in the medical report submitted.

The patient had an EMG scheduled in the beginning of July 2013. Medications included Synovacin-glucosamine sulfate 500 mg bid; diclofenac sodium 1.5% 60 g, apply TID; Gralise ER 600 mg 3 tabs with dinner; Buprenorphine 0.25 sublingual troches tid prn; Capsaicin 0.075% cream apply to affected area tid; and Mirtazapine 15 mg qhs. According to the UR Summary dated 2/13/13, the provider reported that there was an absence of high levels of psychological distress, patient does not smoke and does not require high levels of opioid medication to control the symptoms. The patient was diagnosed with lumbar disc displacement without myelopathy (722.10); pain in joint, lower leg (719.46); and degeneration of lumbar or lumbosacral intervertebral disc (722.52). According to the Visit Note dated 6/21/13 by [REDACTED]

[REDACTED] the MRI on right shoulder documented a supraspinatus tendinopathy.

This is a review for medical necessity of the requested Psychology Consult; Cognitive Behavior Therapy (CBT), one-time per week for 12 weeks; Physical Therapy sessions 2 times per week for 6 weeks for the right shoulder; Cortisone injection for the right shoulder; Cervical epidural steroid injection at C4; Cervical epidural steroid injection at C5; Cervical myelography; Cervical Epidurography and the Insertion of cervical catheter.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review (dated 7/2/13)
- Utilization Review Determination from [REDACTED] (dated 7/9/13)
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request twelve physical therapy sessions for right shoulder (two times a week for six weeks) :

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine Guidelines, page 99, which is part of the MTUS, and Official Disability Guidelines, Shoulder, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 98-99, which are part of the MTUS, and the Official Disability Guidelines (ODG), Shoulder, Physical Therapy, which is not part of the MTUS.

Rationale for the Decision:

The MTUS Chronic Pain Guidelines indicate that physical therapy should allow for fading frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. The treating provider indicates the employee has not received physical therapy for the right shoulder to date. However, review of prior records indicates that the employee has been treated with physical therapy and chiropractic care. Furthermore, the employee has participated in a functional restoration program to date. Therefore, records are not consistent with the treating provider's statement regarding past medical history. In addition, the request for 12 sessions of physical therapy exceeds evidence based guidelines for initial and total duration of care for the employee's diagnosis. There are no exceptional factors to warrant exceeding evidence based guideline criteria. **The request for twelve physical therapy sessions for the right shoulder (two times a week for six weeks) is not medically necessary and appropriate.**

2) Regarding the request for a cervical epidural steroid injection at C4 :

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), criteria for use of epidural steroid injections, page 46, which is part of the MTUS.

Rationale for the Decision:

MTUS Chronic Pain guidelines recommend that patients have radiculopathy on physical examination corroborated by imaging and/or electrodiagnostic studies prior to epidural steroid injections. The documentation submitted for review indicates that the employee has MRI evidence of disc bulging in the cervical spine. However, the independent MRI study was not submitted for review. The independent electrodiagnostic study was submitted for review and revealed no evidence of cervical radiculopathy. Given the lack of corroborating diagnostic findings, the request for cervical epidural steroid injection at C4 is not supported by the guidelines. **The request for a cervical epidural steroid injection at C4 is not medically necessary and appropriate.**

3) Regarding the request cervical epidural steroid injection at C5 :

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite guidelines from which to base its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), criteria for use of epidural steroid injections, page 46, which is part of the MTUS.

Rationale for the Decision:

MTUS Chronic Pain guidelines recommend that patients have radiculopathy on physical examination corroborated by imaging and/or electrodiagnostic studies prior to epidural steroid injections. The documentation submitted for review indicates that the employee has MRI evidence of disc bulging in the cervical spine. However, the independent MRI study was not submitted for review. The independent electrodiagnostic study was submitted for review and revealed no evidence of cervical radiculopathy. Given the lack of corroborating diagnostic findings, the request for cervical epidural steroid injection at C4 is not supported by the guidelines. **The request for a cervical epidural steroid injection at C5 is not medically necessary and appropriate.**

4) Regarding the request for a cervical myelography :

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Neck and Upper Back, Myelography section, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on ODG Neck and Upper Back Chapter, Online Edition, Criteria for myelography and CT myelography, which is not part of the MTUS.

Rationale for the Decision:

Official Disability Guidelines recommend myelography for patients suspected of a CSF leak, for surgical planning, for radiation therapy, suspicion of infection, poor correlation of physical findings with MRI studies, and contraindications for MRI. The employee has undergone an MRI that is supposedly consistent with physical exam findings. However, independent MRI study was not submitted for review. Based on the review of records, it appears that the request for cervical myelography is in conjunction with the proposed cervical epidural steroid injection. As described above, the request for cervical epidural steroid injection is not medically necessary at this time. Therefore, concurrent cervical myelography would not be supported. If in fact the employee is being recommended for diagnostic myelography not part of the injection, there is no indication for this type of study at this time. **The request for a cervical myelography is not medically necessary and appropriate.**

5) Regarding the request for a cervical epidurography

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the following website: <http://www.ncbi.nlm.nih.gov/pubmed/10319985>, which is not part of the MTUS.

The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, criteria for use of epidural steroid injections, page 46, which is part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The MTUS Chronic Pain guidelines indicate that the purpose of an 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. The request for epidurography is for concurrent use with the proposed cervical epidural steroid injection. However, as the concurrent request for cervical epidural steroid injection is not supported at this time, the request for epidurography would likewise not be supported. **The request for a cervical epidurography is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/bh

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.