Case Number:	CM16-0247274		
Date Assigned:	12/30/2016	**Date of Injury:**	10/31/2016
Decision Date:	02/03/2017	**UR Denial Date:**	12/22/2016
Priority:	Standard	**Application Received:**	12/23/2016

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: Texas, California, New Mexico
Certification(s)/Specialty: Orthopedic Surgery, Sports 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:

This case involves a now 28-year-old female with a history of an occupational claim from 10/31/2016. The mechanism of injury is detailed as a motor vehicle accident. The current diagnoses are documented as cervicalgia, lumbago with sciatica, and pain in thoracic spine. Prior relevant treatment included physical therapy, cold therapy unit, and medications. Relevant medications included cyclobenzaprine, propranolol, oxycodone/acetaminophen, and hydrocodone. On 12/05/2016, the patient was seen for an evaluation regarding continued pain rated at a 9/10 with radiation to the left arm. The patient also reported muscle spasms, numbness, and weakness of the bilateral upper extremity, left greater than right. It was noted that the patient would start physical therapy on 12/06/2016. The physical examination revealed restricted range of motion of the cervical spine with tenderness to palpation of the paravertebral muscles, hypertonicity and spasms. Evaluation of the thoracic spine revealed tenderness to palpation with muscle spasms bilaterally. Evaluation of the lumbar spine revealed restricted range of motion with negative facet loading and straight leg raise. Evaluation of the upper extremities revealed negative Neer's, Hawkins', empty can, and short arm crossover test, no swelling, deformities, joint asymmetry or atrophy. Motor strength was normal at 5/5 with decreased sensation over the lateral forearm on the right. The treatment plan included continuation of medications, physical therapy, injections, and transcutaneous electrical nerve stimulation unit trial, MRI of the cervical and thoracic spine, acupuncture, and psych consultation. The Request for Authorization form was dated 12/15/2016. A prior review dated 12/22/2016 indicated that the requested neuroplasty procedure, and injections were non-certified due to a lack of radiculopathy in the L5-S1

distribution. Additionally, the requested physical therapy examination and physical therapy were approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neuroplasty, lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

MAXIMUS guideline: The Expert Reviewer based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Adhesiolysis, percutaneous.

Decision rationale: The California MTUS/ACOEM Guidelines do not specifically address the request for neuroplasty. According to the Official Disability Guidelines, percutaneous adhesiolysis is also referred to as epidural neurolysis, epidural neuroplasty or lysis of epidural adhesions. This procedure is not recommended due to the lack of sufficient literature evidence. Per the submitted documentation, the patient complained of continued pain of the lower back. The most recent physical examination revealed decreased range of motion and tenderness to palpation with negative lumbar facet loading and straight leg raise. There was no clear rationale for the requested procedure. There were no exceptional factors to warrant the requested procedure outside of guidelines. In addition, there was a lack of documented evidence the patient has failed an exhaustive conservative treatment as the patient was recently authorized physical therapy and the treatment plan included injections. As such, the request is not medically necessary.

Injection of neurolytic substance, lumbar spine: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not medically necessary per the documentation, the requested ancillary service is not medically necessary.

Right L5-S1 epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural steroid injections (ESIs).

Decision rationale: ACOEM Guidelines indicate that although epidural steroid injections may afford short term improvement in leg pain and sensory deficits in patients with nerve root compression, the treatment offers no significant long term functional benefit nor does it reduce the need for surgery. More specifically, the Official Disability Guidelines recommend epidural steroid injections for short term treatment of radicular pain with documented evidence of radiculopathy on examination, corroborative imaging studies and/or electrodiagnostic testing following failure of conservative treatment. The clinical information indicated the patient complained of continued pain of the lumbar spine. The most recent physical examination revealed tenderness to palpation and limited range of motion. However, there was a lack of significant objective findings indicative of radiculopathy at the specified levels to support the requested injection. In addition, there was a lack of imaging studies demonstrating radiculopathy at the specified levels for injection. Moreover, there was a lack of documentation indicating the patient has failed conservative treatment with physical therapy prior to the requested injections. As such, the request is not medically necessary.

Left L5-S1 epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

Decision rationale: ACOEM Guidelines indicate that although epidural steroid injections may afford short term improvement in leg pain and sensory deficits in patients with nerve root compression, the treatment offers no significant long term functional benefit nor does it reduce the need for surgery. More specifically, the Official Disability Guidelines recommend epidural steroid injections for short term treatment of radicular pain with documented evidence of radiculopathy on examination, corroborative imaging studies and/or electrodiagnostic testing following failure of conservative treatment. The clinical information indicated the patient complained of continued pain of the lumbar spine. The most recent physical examination revealed tenderness to palpation and limited range of motion. However, there was a lack of significant objective findings indicative of radiculopathy at the specified levels to support the requested injection. In addition, there was a lack of imaging studies demonstrating radiculopathy at the specified levels for injection. Moreover, there was a lack of documentation indicating the patient has failed conservative treatment with physical therapy prior to the requested injections. As such, the request is not medically necessary.

Physical therapy evaluation, cervical and thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Low Back.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Office visits.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines indicate that the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The clinical information indicated the patient complained of continued pain of the lumbar spine. The prior review dated 12/22/2016 indicated that the requested physical therapy evaluation and treatment with 6 sessions was previously authorized. As such, authorization of the request would be redundant. As such, the request is not medically necessary.

Physical therapy, 6 sessions, cervical and thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back; Low Back.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Physical medicine treatment.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines recommend up to 10 sessions of physical therapy for myalgia and myositis. The clinical information indicated the patient complained of continued pain of the lumbar spine. The prior review dated 12/22/2016 indicated that the requested physical therapy evaluation and treatment with 6 sessions was previously authorized. As such, authorization of the request would be redundant. As such, the request is not medically necessary.