

<b>Case Number:</b>	CM13-0063467		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	05/26/2005
<b>Decision Date:</b>	05/12/2014	<b>UR Denial Date:</b>	11/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 is a patient with a date of injury of 5/26/05. A utilization review determination dated 11/22/13 recommends non-certification of cervical ESI, right shoulder subacromial injection, and PT for the right shoulder. 10/30/13 medical report identifies right-sided neck pain with movement, right shoulder pain, has had neck therapy in the past. On exam, Spurling's test is positive for increased pain on the right. There is limited ROM of the neck. Right biceps strength is 4/5.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **CERVICAL EPIDURAL STEROID INJECTION AT C4-5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (Esi).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (Esi) Page(s): 46.

**Decision rationale:** Regarding the request for cervical epidural steroid injection at C4-5, California MTUS cites that ESI is recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy), and radiculopathy must be documented by physical examination and corroborated by imaging studies

and/or electrodiagnostic testing. Within the documentation available for review, the subjective, objective, and imaging findings do not corroborate radiculopathy at the proposed injection level. In the absence of such documentation, the currently requested cervical epidural steroid injection at C4-5 is not medically necessary.

**RIGHT SHOULDER SUBACROMIAL INJECTION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

**Decision rationale:** Regarding the request for right shoulder subacromial injection, California MTUS supports two or three subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears. Additionally, they support diagnostic lidocaine injections to distinguish pain sources in the shoulder area. Within the documentation available for review, there is shoulder pain, but no documentation of findings consistent with rotator cuff pathology. In light of the above issues, the currently requested right shoulder subacromial injection is not medically necessary.

**PHYSICAL THERAPY FOR THE RIGHT SHOULDER, THREE (3) TIMES A WEEK FOR SIX (6) WEEKS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

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

**Decision rationale:** Regarding the request for physical therapy for the right shoulder, three (3) times a week for six (6) weeks, California MTUS supports up to 10 PT sessions for the treatment of this condition. Within the documentation available for review, there is documentation identifying that the patient had not had PT for approximately 2 years prior to the date of the request. Given the patient's shoulder pain, a short course of PT may be appropriate to address the patient's complaints and reinforce an independent home exercise program. However, there is no clear rationale for exceeding the 10 sessions recommended by the CA MTUS and, unfortunately, there is no provision for modification of the request. In light of the above issues, the currently requested physical therapy for the right shoulder, three (3) times a week for six (6) weeks is not medically necessary.