MAXIMUS Federal Services

Case Number:	CM13-0065015		
Date Assigned:	01/03/2014	Date of Injury:	08/17/2011
Decision Date:	04/18/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	12/12/2013

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 male patient with the date of injury of August 17, 2011. A utilization review determination dated November 19, 2013 recommends non-certification of lumbar epidural steroid injection and physical therapy two times a week for four weeks for bilateral shoulders and wrists. The previous reviewing physician recommended non-certification of lumbar epidural steroid injection and non-certification of physical therapy two times a week for four weeks for bilateral shoulders and wrists due to lack of documentation of a current narrative report/PR-2 from the requesting physician indicating physical/objective findings to support the requests. A Reevaluation dated October 16, 2013 identifies Subjective findings of right shoulder pain, low back pain, left leg pain, and neck pain. The patient states he has not had physical therapy since his surgery on his right shoulder. He did have improvement after having epidural injection #1, but his pain is returning gradually. Focused Examination identifies positive right deltoid and supraspinatus tenderness. Decreased right shoulder ROM Strength 3+/5. Decreased lumbar spine ROM. Positive Finkelstein's on the right. Diagnoses identify wrist arthralgia, cervical spondylosis, lumbar herniated nucleus pulposus, lumbar stenosis, lumbago, shoulder impingement/bursitis, nonunion of fracture, fracture navicular (scaphoid) closed, shoulder sprain/strain rotator cuff, wrist sprain/strain other, cervical myofascitis sprain-strain, thoracic sprain/strain, lumbar myofascial sprain-strain, aftercare surgery unspecified. Recommendations identify lumbar epidural steroid injection #2 with pain management. The patient experienced improvement with the low back pain and leg pain since receiving injection #1. Request authorization for additional physical therapy for bilateral shoulders and wrists twice weekly x4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Decision for Lumbar Epidural Steroid Injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Reed Group/The medical Disability Advisor and Official Disability Guidelines/ Integrated Treatment Guidelines (ODG Treatment in Worker comp 2nd Edition)- Disability Duration Guidelines(Official Disability Guidelines 9th Edition)/Work Loss Data Institute.

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

Decision rationale: Regarding the request for lumbar epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy. Regarding repeat epidural injections, guidelines state that 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. Within the documentation available for review, it's noted that previous injection provided the patient with improvement in low back and leg pain. However, there is no documentation of continued objective documented functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. In the absence of such documentation, the currently requested lumbar epidural steroid injection is not medically necessary and appropriate.

Decision for Physical Therapy Two Times A Week For Four Weeks For Bilateral Shoulders And Wrists: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Reed Group/The medical Disability Advisor and Official Disability Guidelines/ Integrated Treatment Guidelines (ODG Treatment in Worker comp 2nd Edition)- Disability Duration Guidelines(Official Disability Guidelines 9th Edition)/Work Loss Data Institute.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 200,265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy and Forearm, Wrist & Hand Chapter, Physical Therapy.

Decision rationale: Regarding the request for Physical Therapy Two Times A Week For Four Weeks For Bilateral Shoulders And Wrists, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication of any objective functional

improvement from the therapy already provided, no documentation of specific ongoing objective treatment goals, and no statement indicating why an independent program of home exercise would be insufficient to address any remaining objective deficits. In the absence of such documentation, the current request for physical therapy two times a week for four weeks for bilateral shoulders and wrists is not medically necessary.