

<b>Case Number:</b>	CM14-0001363		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	12/28/2004
<b>Decision Date:</b>	06/13/2014	<b>UR Denial Date:</b>	12/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/03/2014

### 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 Occupational Medicine 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:

The patient is an employee of [REDACTED], and has submitted a claim for Rotator Cuff Syndrome associated with an industrial injury date of December 28, 2004. The treatment to date has included oral analgesics, physical therapy, and cervical epidural steroid injection. Medical records from 2013 were reviewed and showed neck and bilateral shoulder pain. Physical examination revealed gross tenderness of the posterior neck muscles, trigger points on the right side of the cervical spine, positive foraminal compression test of the neck bilaterally, trapezial muscle spasms, generalized cervical muscle weakness secondary to pain and limitation of motion. MRI of the cervical spine on April 26, 2013 revealed an uncovertebral spur and facet arthropathy with mild to moderate C7-T1 foraminal narrowing and mild bilateral neuroforaminal narrowing at C4-5 and C5-6. An epidural steroid injection was performed before which resolved the pain on the left side of the neck. The patient has residual pain on the right side of the neck for which another cervical ESI was given on November 4, 2013. Physical therapy was requested for post-injection rehabilitation. The utilization review dated December 12, 2013 denied the requests for second CESI at C5-7 because the medical records did not document at least 50% pain relief lasting 6-8 weeks and PT 3x2 due to no documented response to prior therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SECOND CESI AT C5-C7:** 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 Injection Page(s): 46.

**Decision rationale:** Page 46 of the California MTUS Chronic Pain Medical Treatment Guidelines state that epidural steroid injection (ESI) is an option for treatment of radicular pain. The current recommendations suggest a second epidural injection if partial success is produced with the first injection. 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. In this case, the patient had a previous cervical epidural steroid injection which resolved the pain of the left side of the neck; however, it is unclear how long the pain relief lasted. The guideline recommends a repeat block when at least 50% of pain relief is sustained for 6-8 weeks. Furthermore, the present request failed to specify the laterality. The medical necessity has not been established. Therefore, the request for a second CESI at C5-C7 is not medically necessary.

**PHYSICAL THERAPY THREE TIMES PER WEEK FOR TWO WEEKS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

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

**Decision rationale:** Page 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines stress the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment. In this case, physical therapy was requested for post-injection rehabilitation. The patient has undergone physical therapy sessions; however, there was no documentation of overall pain improvement and functional gains derived from the treatment. Moreover, the functional goals of the treatment were not discussed. The medical necessity has not been established. The body part to be treated is likewise not specified. Therefore, the request for physical therapy three times per week for two weeks is not medically necessary.