

Case Number:	CM14-0104218		
Date Assigned:	07/30/2014	Date of Injury:	05/18/2011
Decision Date:	09/24/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/07/2014

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 Family 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 a 48-year-old male who has submitted a claim for cervical, thoracic and lumbar spine sprain/strain, status post right shoulder surgery, status post right ulnar nerve release, status post right elbow surgery, status post right knee arthroscopy for medial meniscectomy and patellar chondroplasty, sleep disruption, daytime cognitive fatigue, and right greater trochanteric bursitis associated with an industrial injury date of May 18, 2011. Medical records from 2014 were reviewed. The patient complained of right shoulder, right elbow, right hand, and neck pain. The neck pain was rated 9/10 and also has thoracic spine pain that radiates between the shoulder blades. The right shoulder pain was rated 7/10 in severity. His right hand cramps after writing half an hour. The patient recently fell and hit the inner part of his left elbow. Physical examination showed limited range of motion of the cervical and thoracic spine. Right shoulder examination showed decreased range of motion as well. There was decreased strength in the right upper extremity, first and second digit opposition strength and abductor minimus strength. Sensation was decreased on the right upper extremity. There was noted tenderness on the medial aspect of the left elbow. Range of motion was normal. MRI of the cervical spine dated June 20, 2011 showed multilevel degenerative disc disease and spondylosis, most advanced at C5-C6 and C6-C7 where there is borderline cord compression, and borderline exiting bilateral C7 nerve root impingement. Official report of the imaging study was not available. Treatment to date has included medications, physical therapy, home exercise program, activity modification, TENS unit, right elbow surgery, right shoulder surgery, right knee arthroscopic meniscectomy, right ulnar nerve release, and lumbar medial branch block. Utilization review, dated June 25, 2014, denied the request for cervical epidural steroid injection interlaminar right C7-T1 because no details regarding her neck pain and arm pain were available and previous injection failed to show

sufficient relief; and denied the request for x-ray left elbow because there was no mention of any significant swelling, discoloration, or loss of function.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Epidural Steroid Injection, Interlaminar right C7- T1: Upheld

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

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

Decision rationale: As stated on page 46 of the CA MTUS Chronic Pain Medical Treatment Guidelines, criteria for epidural steroid injections include the following: radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing; initially unresponsive to conservative treatment; and no more than two nerve root levels should be injected using transforaminal blocks. Guidelines do not support epidural injections in the absence of objective radiculopathy. In addition, repeat epidural steroid injections 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, progress report dated May 27, 2014 state that the patient had an epidural in his neck last October 20, 2011 which provided one month of relief. However, objective pain relief measures and evidence of functional improvement were not documented. There was also failure to exhibit any evidence of improved performance of activities of daily living and there was no associated reduction of medication intake from the treatment. MRI of the cervical spine dated June 20, 2011, revealed C5-C6 and C6-C7 borderline cord compression, and borderline exiting bilateral C7 nerve root impingement. Physical examination showed decreased strength and sensation in the right upper extremity. The physical examination findings are not consistent with the patient's MRI. Furthermore, there was no evidence that patient was unresponsive to conservative treatment. The guideline criteria have not been met. Therefore, the request for Cervical Epidural Steroid Injection, Interlaminar right C7- T1 is not medically necessary.

X-ray Left Elbow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 42-43.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow Section.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, radiographs are required before other

imaging studies and may be diagnostic for osteochondral fracture, osteochondritis dissecans, and osteocartilaginous intra-articular body. Those patients with normal extension, flexion and supination do not require emergent elbow radiographs. In this case, patient was being requested to an x-ray of the left elbow because he has pain after falling and hitting his left elbow when his right knee gave way. However, physical examination only showed tenderness with normal range of motion. There is not enough evidence for an elbow x-ray to be medically necessary. Therefore, the request for X-ray Left Elbow is not medically necessary.