

Case Number:	CM14-0010265		
Date Assigned:	02/21/2014	Date of Injury:	04/05/2004
Decision Date:	08/05/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/23/2014

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 Orthopedic Surgery 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:

Patient is a 56-year-old female who has submitted a claim for neck pain, cervical spine degenerative disc disease, cervical spine herniated disks, bilateral upper extremity radiculitis, lumbosacral radiculitis, low back pain, right rotator cuff tendinitis, right shoulder impingement syndrome, status post left shoulder arthroscopy, left shoulder tendinitis, status post left lateral epicondylectomy and fasciotomy, left medial epicondylitis, and right long finger and thumb trigger finger associated with an industrial injury date of 04/05/2004. Medical records from 2013 were reviewed. Patient complained of neck pain associated with numbness and tingling sensation at the right upper extremity. She likewise reported pain in her elbows, thumb, trigger long finger, right shoulder, and low back. Physical examination of the cervical spine showed tenderness, muscle spasm, negative for Spurling's test, and painful range of motion. Physical examination of the lumbar spine showed tenderness and normal range of motion. Motor strength and reflexes of bilateral lower extremities were normal. Sensation was diminished at C6 to C8 dermatomes, right. Physical examination of the right shoulder showed positive Neer's and Hawkin's tests. Right shoulder abductors and external rotators were graded 4/5 in strength testing. Physical exam of the right elbow showed negative tenderness, negative Tinel's sign, normal motor strength, and normal range of motion. MRI of the lumbar spine, dated July 12, 2012, showed multi-level disc desiccation; at L4 to L5 there was a 4-mm right paramedian protrusion with annular tear indenting the thecal sac and abutting the right L5 nerve in the moderately stenotic right greater than left central canal. At L5 to S1, there was a central canal mild stenosis, and mild right neural foramina encroachment. At L2 to L4, there was a slight central canal narrowing and the disc indenting the thecal sac. MRI of the cervical spine from March 21, 2008, showed multi-level posterior disc protrusion with patent neuroforamina. Treatment to date has included cervical epidural steroid injection, massage,

physical therapy, home exercise program, left shoulder surgery, left elbow surgery, right knee surgery, right shoulder injection, and medication such as Diclofenac, Tramadol, Ondansetron, and Omeprazole. Utilization review from 01/06/2014 denied the request for right shoulder arthroscopy because there was no MRI submitted in the records; denied right elbow lateral fasciotomy because there was no failure of conservative care; and denied cervical and lumbar spine epidural steroid injections because electrodiagnostic testing or imaging studies were not submitted. The requests for post-op physical therapy for the right shoulder and right elbow, and VascuTherm cold compression were denied because surgery was likewise denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPY, SUBACROMIAL DECOMPRESSION AND AC JOINT RESECTION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 210.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Section, Diagnostic Arthroscopy.

Decision rationale: CA MTUS ACOEM Practice Guidelines Chapter 9 supports surgical intervention for patients who have: (1) red flag conditions; (2) activity limitation for more than four months, plus existence of a surgical lesion; (3) failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion; (4) clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long-term, from surgical repair. In addition, ODG states that diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. In this case, patient complained of right shoulder pain despite cortisone injection. Physical examination showed positive Neer's and Hawkin's tests. Right shoulder abductors and external rotators were graded 4/5 in strength testing. However, medical records submitted and reviewed failed to provide evidence of failure in physical therapy. The official MRI of the right shoulder was likewise not available for review. The medical necessity was not established due to insufficient information. Therefore, the request for right shoulder arthroscopy, subacromial decompression and ac joint resection is not medically necessary.

POST OP PHYSICAL THERAPY FOR THE RIGHT SHOULDER, THREE (3) TIMES A WEEK FOR SIX (6) WEEKS: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

POST OP PHYSICAL THERAPY FOR THE RIGHT ELBOW, THREE (3) TIMES A WEEK FOR SIX (6) WEEKS: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

VASCUTHERM 4 COLD COMPRESSION - 21 DAY RENTAL: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

RIGHT ELBOW LATERAL FASCIOTOMY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 35.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Forearm Fasciotomy, Wheeless' Textbook of Orthopedics.

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, and the Wheeless' Textbook of Orthopedics was used instead. It states that indications for fasciotomy include 4 to 6 hours delay after injury, combined vein and artery injury, arterial ligation, severe soft tissue injury, muscle edema, patchy necrosis, and compartment pressure exceeding 40 mmHg. In this case, patient complained of right elbow pain. However, physical examination showed negative tenderness, negative Tinel's sign, normal motor strength, and normal range of motion. There was no documented rationale for this procedure. The medical necessity was not established due to unremarkable physical examination findings. Therefore, the request for right elbow lateral fasciotomy is not medically necessary.

CERVICAL SPINE EPIDURAL INJECTION - TIMES TWO (2): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS Page(s): 46.

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

Decision rationale: As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. In this case, patient complained of neck pain associated with numbness and tingling sensation at the right upper extremity. Physical examination of the cervical spine showed tenderness, muscle spasm, negative for Spurling's test, and painful range of motion. Reflexes were normal. Sensation was diminished at C6 to C8 dermatomes, right. MRI of the cervical spine from March 21, 2008, showed multi-level posterior disc protrusion with patent neuroforamina. A report from October 13, 2013 cited the patient underwent two sessions of cervical epidural steroid injection. Patient reported 25% to 30% pain relief which lasted for 2 to 3 months. Of note, patient underwent C7 to T1 cervical epidural steroid injection on December 23, 2013. However, epidural steroid injection is not warranted in this case because of patent neuroforamina findings in the MRI. Moreover, it is not recommended to certify two sessions of cervical ESI without assessment of response from the previous session. Furthermore, the request failed to specify the level and laterality intended for injection. Therefore, the request for cervical spine epidural injection x 2 is not medically necessary.

LUMBAR SPINE EPIDURAL INJECTION - TIMES TWO (2): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS Page(s): 46.

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

Decision rationale: As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. In this case, patient complained of low back pain. Physical examination of the lumbar spine showed tenderness and normal range of motion. Motor strength and reflexes of bilateral lower extremities were normal. MRI of the lumbar spine, dated July 12, 2012, showed multi-level disc desiccation; moderately stenotic right greater than left central canal at L4-L5; and mild right neural foramina encroachment at L5-S1. Although the MRI findings showed mild to moderate neural foramina narrowing, clinical manifestations are not consistent with

radiculopathy. Moreover, it is not recommended to certify two sessions of ESI without assessment of response from the previous session. Furthermore, the request failed to specify the level and laterality intended for injection. Therefore, the request for lumbar spine epidural injection x 2 is not medically necessary.