

Case Number:	CM14-0136589		
Date Assigned:	09/03/2014	Date of Injury:	09/30/2011
Decision Date:	10/02/2014	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/25/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 62-year-old female with a date of injury of 09/30/2011. The listed diagnoses per [REDACTED] are: 1.Lumbago.2.Pain in limb.3.Disturbance skin sensation.4. Displaced lumbar intervertebral.5.Neck painAccording to progress report 06/26/2014, the patient presents with left shoulder pain and intense right hand pain. Examination revealed triggers in the cervical spine and tenderness over the TFCC of the wrist. The provider is requesting cervical epidural steroid injection x2 for C4-C5 and C5-C6, post-injection physical therapy 3x3, and an MRI of the right wrist. Utilization review denied the requests on 07/31/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural steroid injections C4-6 x 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines The Medical Treatment Utilization Schedule has the following regarding ESI's, under its chronic Chronic Pain Section, page 46 and 47.

Decision rationale: This patient presents with chronic low back and neck pain. The provider Guidelines has the following regarding ESI under chronic pain section page 46 and 47, "Recommended as an option for treatment of radicular pain defined as pain in dermatomal distribution with corroborative findings of radiculopathy." In this case, the patient presents with neck pain and tenderness but no dermatomal distribution of pain is described. In addition, there are no diagnostic studies corroborating dermatomal distribution of pain/paresthesia which is required by MTUS. Therefore, this request is not medically necessary.

Post ESI physical therapy 3 x 3 sessions.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

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

Decision rationale: This provider is requesting post-epidural steroid injection physical therapy 3 times a week for 3 weeks. The ACOEM, MTUS and ODG guidelines do not discuss physical therapy following epidural steroid injections. For physical medicine, the MTUS guidelines page 98, 99 recommends for myalgia, myositis and neuritis 9-10 sessions over 8 weeks. Review of the medical file indicates the patient received 9 physical therapy sessions in 2012. Given the patient has not been recommended for a Cervical Epidural Injection, the requested post-CESI physical therapy is not medically necessary. Therefore, this request is not medically necessary.

MRI of the right wrist.: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268.

Decision rationale: This patient presents with low back, neck, and right wrist complaints. The provider is requesting an MRI of the right wrist. Utilization review denied the MRI stating, "Although imaging is optional for the wrist, there is no evidence here of conservative measure to treat the wrist pain." ACOEM guidelines Chapter 11, page 268-269 has the following regarding special studies and diagnostic and treatment considerations: "for most patients presenting with true hand and wrist problems, special studies are not needed until after a four to six week period of conservative care and observation." For MRI of the wrist, ODG guidelines states, "Magnetic resonance imaging has been advocated for patients with chronic wrist pain because it enables clinicians to perform a global examination. It may be diagnostic in patients with triangular fibrocartilage (TFC) and intraosseous ligament tears, occult fractures, and avascular neurosis." There is no indication the patient had prior MRI of the wrist. In this case, the provider describes well over 6 months of right wrist complaints. At this point, due to the chronicity of the issue, a MRI of the right wrist is warranted. The requested MRI of the right wrist is medically necessary and recommendation is for approval.

