

Case Number:	CM14-0156870		
Date Assigned:	09/26/2014	Date of Injury:	08/17/2010
Decision Date:	10/27/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/25/2014

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 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:

This is a 42-year-old female patient who reported an industrial injury on 8/17/2010, over four (4) years ago, attributed to the performance of her usual and customary job duties. The AME evaluation dated 6/2/2014 documented the diagnoses of cervical spine 3.4 mm disc protrusion at C5-C6 with impingement on the left C6 nerve root and a 2.5 mm disc protrusion at C4-C5 per MRI dated 10/20/2011; right shoulder infraspinatus tendinosis with mild AC joint osteoarthritis with type III acromion; right elbow ulnar nerve cubital tunnel syndrome; right elbow medial epicondylitis; right medial and lateral epicondylitis; right wrist sprain/strain; status post reconstruction of the tendon sheaths for sub Lexington extensor carpi ulnaris using extensor retinaculum and partial tenosynovectomy; right wrist mild tendinosis and Palmer subluxation of extensor carpi ulnaris tendon with chronic extensor carpi ulnaris tendon subsheath injury. The patient was requested to have a follow up evaluation with pain management for a possible cervical spine epidural steroid injection. The patient complained of right shoulder pain with reduced range of motion along with wrist and arm pain. The objective findings on examination included forward flexion right shoulder 120 and abduction 125. The patient was diagnosed with anemia secondary G.I. bleed; cognitive disorder; major depression; anxiety; pain disorder; degenerative joint disease of the right elbow; right shoulder internal derangement; right elbow internal derangement; internal derangement right wrist; ankylosing traumatic elbow; HNP cervical; cervical radiculopathy; right shoulder impingement syndrome; sleep disorder; cervicogenic headaches; and cervical musculoligamentous injury. The patient was prescribed a GI evaluation for treatment of H. pylori a; a urine drug screen; Cymbalta dirty milligrams; Xanax 0.5 mg; Flector patches; topical compounded cream; a Toradol IM injection administered; and a referral to pain management for a cervical ESI.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow Up Visit with Pain Management: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 300, 179-180, 174-175. Decision based on Non-MTUS Citation ODG) Section neck and upper back chapter epidural steroid injections

Decision rationale: The request for the cervical spine ESI is inconsistent with the recommendations of evidence-based guidelines, as the patient is not documented to have objective findings consistent with an acute nerve impingement radiculopathy. There are no recommendations for a cervical ESI as for degenerative disc disease. The pain diagram demonstrated by the patient did not document a radicular pattern for the describe pain to the neck and shoulder. The MRI of the cervical spine does not demonstrate a nerve impingement radiculopathy. There is no electrodiagnostic evidence of a progressive radiculopathy. There are no documented neurological deficits that are progressive on physical examination. The patient was referred to pain management for a cervical ESI based on findings on the MRI three (3) years ago without any Electrodiagnostic evidence of a nerve impingement radiculopathy. The MRI demonstrated evidence of disc encroachment to the left C6 nerve root; however, there were no objective findings on examination of any sensory deficits or any Electrodiagnostic findings consistent with a left C6 radiculopathy. Such as, Follow-Up Visit with Pain Management is not medically necessary.