

Case Number:	CM14-0178456		
Date Assigned:	10/31/2014	Date of Injury:	10/12/2011
Decision Date:	12/08/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/28/2014

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 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 injured worker is a 47-year-old female who reported an injury on 10/12/2011. The mechanism of injury was not submitted for clinical review. The diagnoses included cervicalgia, tenosynovitis of the hand, affections of the shoulder, status post right shoulder arthroscopy, joint derangement of the right shoulder, and status post surgery of the right wrist veins. The previous treatments included medication, physical therapy, and surgery. Diagnostic testing included MRIs. Within the clinical note dated 09/19/2014, it was reported the injured worker complained of right shoulder pain. She complained of pain to her right shoulder up to her neck. The provider noted the cervical range of motion had pain with flexion/extension. There was a positive Spurling's with radiculopathy to the right shoulder and right arm along the C5-7 dermatomes. The provider noted there was positive tenderness to the right shoulder. The request was submitted for an epidural steroid injection with facet and postoperative physical therapy. However, a rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

ESI with facet C5-7 x 2: Upheld

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

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

Decision rationale: The request for an epidural steroid injection with facet at C5-7 times 2 is not medically necessary. The California MTUS Guidelines recommend epidural steroid injections as an option for the treatment of radicular pain, defined as pain in a dermatomal distribution with corroborative findings of radiculopathy. The guidelines noted that radiculopathy must be documented by a physical examination and corroborated by imaging studies and/or electrodiagnostic study testing, initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs, and muscle relaxants). The guidelines recommend if epidural steroid injections are used for diagnostic purposes, a maximum of 2 injections should be performed. A second block is not recommended if there is an inadequate response to the first block. There was a lack of documentation of imaging studies to corroborate the diagnosis of radiculopathy. There was a lack of documentation indicating the injured worker had tried and failed on conservative therapy. Therefore, the request is not medically necessary.

Post-op physical therapy three times a week for three weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 98.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10.

Decision rationale: The request for postoperative physical therapy 3 times per week for 3 weeks is not medically necessary. The Postsurgical Treatment Guidelines note the initial course of therapy means 1 half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations. The request submitted failed to provide the specific type of postoperative therapy to be administered. Therefore, the request is not medically necessary.