

<b>Case Number:</b>	CM14-0022556		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	08/19/2011
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	01/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2014

### 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 43-year-old female who reported an injury of continuous trauma on 08/19/2011. On 12/03/2013, she presented with complaints of neck pain, with stiffness, numbness and tingling. She further complained of right shoulder elbow and wrist pain with coldness of the hand. The examination of her cervical spine and upper extremities revealed that she moved her head and neck slowly with tenderness, tightness, and discomfort on the right side of her neck. Her cervical spine range of motion was all within normal limits. Her right shoulder ranges of motion measured in degrees were flexion 165/180, extension 30/40, abduction 160/180, adduction 30/30, internal rotation 80/80, and external rotation 80/90. There was a positive impingement sign noted on the right side. The elbow flexion test was positive on the right side as well as Phalen's test and Tinel's sign, which was positive primarily in the 4th and 5th fingers. A review of her medical records revealed an MRI of 10/04/2013 which showed disc disease at C5-6 with a 3.5 ventral impression on the thecal sac. On 05/07/2013, she underwent a right ulnar nerve decompression, arthrotomy of the right elbow and carpal tunnel release on the right side. Her diagnoses included status post right carpal tunnel release and ulnar nerve release, right lateral epicondyle release with arthrotomy of the elbow, impingement of the right shoulder, cervical strain with disc disease at C5-6, and possible double crush syndrome. The treatment plan and recommendations stated that the examining physician wanted to hold off on any further surgeries at that time. It was specifically stated that she should not undergo shoulder surgery until she received treatment for the cervical spine to see if that would have stopped her ongoing symptoms. The recommendation was for pain management and epidural injections, with no body part specified. It further stated that she should continue on the ibuprofen but in the body of the report it stated she was taking no medications. An updated EMG and nerve conduction study was recommended to see if she possibly had double crush syndrome with radiculopathy. On

10/14/2013, her primary complaint was her ongoing right shoulder pain. Her treatments had consisted of activity modification, usage of anti-inflammatory medications, formal therapy, and 3 subacromial steroid injections, which only provided temporary relief of her symptoms. Her secondary complaint was of ongoing neck pain with radiation to the right upper arm. The examination of the cervical spine revealed a positive Spurling's test with radiation of pain to the right shoulder and upper arm. She had a negative cervical compression test. Examination of the right shoulder revealed no gross atrophy or scapular weaning with range of motion. She was tender to palpation along the right proximal biceps tendon/groove. The MRI of the right shoulder dated 02/24/2012 revealed mild tendinosis of the supraspinatus tendon, mild tendinosis of the subscapularis tendon, and mild osteoarthritis of the acromioclavicular joint with down sloping acromion. There was no request for epidural injections submitted with the documents. Request for authorization for the other 4 decisions were included with the documentation. The rationale for pain management consult for cervical was noted as stated earlier that she should not undergo shoulder surgery until she received treatment for the cervical spine to see if that would help her ongoing symptoms. The recommendations were for pain management and epidural injections. There was no rationale found for the request for physical therapy. On 10/14/2013, she was informed of her options which included physical therapy, but she stated that she did not wish to undergo any further non-operative treatment and wanted to proceed with the surgical intervention. There was no rationale submitted for the acupuncture or the continuation of ibuprofen.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **PAIN MANAGEMENT CONSULT FOR CERVICAL: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic, Office visits.

**Decision rationale:** The request for pain management consult for cervical is not medically necessary. The Official Disability Guidelines recommend office visits as determined to be medically necessary. The evaluation and management outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a healthcare provider is individualized based upon the review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgement. The documentation submitted stated that this worker's shoulder complaints were more significant than those of her neck. She stated that she wanted to choose surgical options rather than conservative treatment. There was no evidence submitted of failed trials of NSAIDS, muscle relaxants, antidepressants or anticonvulsants to control her pain. Additionally, the request is incomplete stating pain management consult for cervical but did not mention a particular type of treatment, condition or particular level of the

cervical spine. Therefore, this request for pain management consult for cervical is not medically necessary.

**EPIDURAL INJECTIONS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESI).

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

**Decision rationale:** The request for epidural injections is not medically necessary. The California MTUS recommends epidural steroid injections as an option for treatment of radicular pain...epidural steroid injections can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. Epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not effect impairments of function or the need for surgery and do not provide long-term pain relief beyond 3 months. Among the criteria for use of epidural steroid injections are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, and the condition must be initially unresponsive to conservative treatment including exercises, physical methods, NSAIDS, and muscle relaxants. Also, the injection should be performed using fluoroscopy for guidance. This worker does not have a definitive diagnosis of radicular pain corroborated by imaging studies or electrodiagnostic testing. There were no records submitted of this worker being unresponsive to or having failed trials of conservative treatment including exercise, physical methods, NSAIDS, and muscle relaxants. There was no request that the injections be given under fluoroscopic guidance. Additionally, there were no body parts specified in the request. Therefore, this request for epidural injections is not medically necessary.

**PHYSICAL THERAPY (X12) TO SPINE AND ARM: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE GUIDELINES.

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

**Decision rationale:** The request for physical therapy (x12) to spine and arm is not medically necessary. The California MTUS does recommend physical medicine, which includes passive therapy that can provide short-term relief during the early phases of pain treatment and is directed at controlling symptoms such as pain, inflammation, and swelling and to improve the rate of healing soft tissue injuries. It can be used sparingly with active therapies to help control swelling, pain, and inflammation during the rehabilitation process. Active therapies are therapeutic exercises and/or activities which are beneficial for restoring flexibility, strength, endurance, function, range of motion and can alleviate discomfort. Patients are instructed and

expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. The recommended schedule of visits for myalgia and myositis is 9 to 10 visits over 8 weeks. The requested 12 physical therapy visits exceeds the guideline's allowable schedule. Additionally, no level of the spine was specified nor which arm or what part of the arm was to be treated. Therefore, this request for physical therapy x12 to spine and arm is not medically necessary.

**ACUPUNCTURE (X6): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The request for acupuncture x6 is not medically necessary. The CA MTUS recommends that "acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture is used as an option when pain medication is reduced or not tolerated, The frequency and duration of acupuncture recommended is 3 to 6 treatments to produce functional improvement at 1-3 times per week with an optimal duration of 1 to 2 months. The request did not include frequency or duration of the treatments. Additionally, the body part or parts to be treated were not specified in the request. Therefore, this request for acupuncture x6 is not medically necessary.

**CONTINUE IBUPROFEN: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, NSAIDS (non-steroidal anti-inflammatory drugs).

**Decision rationale:** The request for continue ibuprofen is not medically necessary. The California MTUS recommends NSAIDS at the lowest possible dose for the shortest period of time in patients with moderate to severe osteoarthritis pain. The guidelines further state that there is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis and other nociceptive pain. Ibuprofen is recommended for osteoarthritis, rheumatoid arthritis, and off label for ankylosing spondylitis. Although there is a recommendation to continue ibuprofen, the record clearly stated that this worker was not taking any medications at all. Additionally, the request does not specify a dosage or frequency. Therefore, this request for continue ibuprofen is not medically necessary.