

<b>Case Number:</b>	CM14-0055334		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	06/26/2012
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	04/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2014

### 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 Occupational 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 patient is a 53 year-old female with date of injury 06/26/2012. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 03/21/2014, lists subjective complaints as pain in the neck and right shoulder that radiates down the arm with burning pain. Objective findings: Examination of the cervical spine revealed tenderness to palpation with spasm and trigger points more on the right than left. Decreased range of motion due to pain with restricted rotation of the neck and shoulder. Positive Spurling test. Motor sensory deficit in the right upper extremity (no dermatome mentioned). Diagnosis: 1. Pain in joint, right shoulder 2. Cervicalgia 3. Pain in joint, right hand 4. Carpal tunnel syndrome, right hand. Patient is status post right shoulder arthroscopic surgery on 09/16/2013. Patient underwent an MRI of the cervical spine on 03/11/2013 which was reported: 1. At C3-4, a 2 mm disc central protrusion which mildly impresses on the thecal sac. 2. C5-6, a 2 mm broad based disc protrusion which mildly impresses on the thecal sac. Moderate right neuroforaminal narrowing is noted. 3. C6-7, a 2.9 mm central disc protrusion which mildly impresses on the thecal sac 4. Loss of cervical lordotic curvature. The patient has undergone at least 10 postoperative physical therapy visits.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical Epidural Steroid Injection (ESI) with facet injection C5-6 x 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back Chapter: Facet joint diagnostic blocks.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175.

**Decision rationale:** The MTUS states that cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. Based on the MRI of 03/11/2013, the patient may be a surgical candidate for right C6 nerve root decompression, but the physical exam associated with the request lacks sufficient detail to ascertain which dermatome or myotome is affected. The request is not medically necessary and appropriate.

**Post-operative Physical Therapy 3 times per week for 2 weeks to the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines: Physical Therapy Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 98-99.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Continued physical therapy is predicated upon demonstration of a functional improvement. Although the patient has received 10 visits of physical therapy, there is little documentation of objective functional improvement. The request is not medically necessary and appropriate.