

Case Number:	CM15-0131693		
Date Assigned:	07/17/2015	Date of Injury:	04/04/2003
Decision Date:	08/14/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 44-year-old female who sustained an industrial injury on 4/4/03. Treatments include: medication, physical therapy, cervical epidural injections and right shoulder arthroscopy. Progress report dated 6/8/15 reports continued complaints of right sided neck, upper back with right upper extremity radicular pain and right shoulder pain. The pain radiates to the right top of shoulder, right upper arm, forearm and hand. The pain is described as sharp, throbbing, stabbing, shooting and burning, rated 7/10. Pain medication, muscle relaxant and epidural injections help to relieve the pain. Diagnoses include: severe chronic right cervicgia with right upper extremity radicular pain secondary to degenerative disc disease with radiculitis, chronic right shoulder pain secondary to rotator cuff disorder, status post right shoulder arthroscopic surgery and depression. Plan of care includes: medication refill, continue fentanyl patch, continue Soma, cervical epidural steroid injection under fluoroscopic guidance and right shoulder cortisone injection. Follow up in 1 month.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical ESI under fluoroscopy x 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 46 of 127.

Decision rationale: Regarding the request for epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Regarding repeat epidural injections, guidelines state that repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. Within the documentation available for review, there is no indication of at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks as well as functional improvement from previous epidural injections. Furthermore, there are no current objective and imaging or electrodiagnostic studies confirming a diagnosis of radiculopathy in any specific nerve root distribution(s). As such, the currently requested epidural steroid injection is not medically necessary.

Right shoulder cortisone injection x 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Steroid injections.

Decision rationale: Regarding the request for shoulder injection, CA MTUS and ACOEM support two or three subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears. ODG supports injection when: Pain is not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months; Pain interferes with functional activities (eg, pain with elevation is significantly limiting work); Intended for short-term control of symptoms to resume conservative medical management. Within the documentation available for review, there is no indication of pain with elevation that significantly limits activity following failure of conservative treatment including exercise and that an exercise rehabilitation program is part of the treatment plan following injection. In the absence of clarity regarding the above issues, the currently requested shoulder injection is not medically necessary.