

<b>Case Number:</b>	CM15-0136365		
<b>Date Assigned:</b>	07/27/2015	<b>Date of Injury:</b>	04/27/2013
<b>Decision Date:</b>	09/10/2015	<b>UR Denial Date:</b>	07/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2015

### 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

### 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 52 year old female with an industrial injury dated 01/01/2010 to 08/19/2010 (cumulative trauma). The mechanism of injury is documented as a fall. Her diagnoses included recurrent tear of the left rotator cuff, left subscapularis tear, and non-retracted right rotator cuff tear and biceps tenosynovitis with fraying. Prior treatment included rotator cuff repair. Progress note dated 12-01-2014 notes the injured worker complained of painful shoulders right worse than left. Range of motion was decreased in both shoulders. Qualified medical examination supplemental report dated 06-06-2015 noting full thickness rotator cuff tear of left shoulder with findings of impingement. MRI of cervical spine and electro diagnostic studies are documented as revealing a cervical 6 radiculopathy. Treatment recommended in the qualified medical examination is left sided cervical epidural steroid injections (cervical 5-6 and cervical 6-7). The treatment request is for Cervical Epidural Steroid Injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical Epidural Steroid Injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid injections, page 46.

**Decision rationale:** Review indicates symptom complaints and findings of limited range and decreased deltoid strength pertains to shoulder diagnosis. MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); however, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not provided here. Submitted reports have not demonstrated any specific neurological deficits of the cervical spine to support the epidural injections. There is no report of acute new injury, flare-up, progressive neurological deficit, or red-flag conditions to support for pain procedure. There is also no documented failed conservative trial of physical therapy, medications, activity modification, or other treatment modalities to support for the epidural injection. Cervical epidural injections may be an option for delaying surgical intervention; however, there is not surgery planned or collaborated clinical exam with identified pathological lesion noted. Criteria for the epidurals have not been met or established. The Cervical Epidural Steroid Injection is not medically necessary or appropriate.