

Case Number:	CM15-0138123		
Date Assigned:	07/28/2015	Date of Injury:	10/28/2014
Decision Date:	08/26/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/16/2015

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 37 year old female, who sustained an industrial injury on October 28, 2014. She reported head, right arm and right hand pain. Treatment to date has included medication, physical therapy, MRI, x-rays, and acupuncture. An electrodiagnostic study has been performed. Currently, the injured worker complains constant right wrist and hand pain with numbness, burning and aching. The pain is exacerbated by gripping, grasping, pulling, pushing, lifting, turning and repetitive use of the right upper extremity and is rated 7-8 on 10 without medication and 1-2 on 10 with medication. She reports neck and upper back pain that radiates into her right arm. The pain is exacerbated by bending, pulling, pushing, lifting and use of the right wrist. She reports constant and sharp lower back pain that is exacerbated by bending, twisting, lifting, prolonged sitting and standing. She reports the pain causes her to experience difficulty rising from a lying down position. The injured worker is diagnosed with right hand sprain-strain, internal derangement carpal syndrome, right wrist sprain-strain (rule out internal derangement), cervical spine sprain-strain, herniated cervical disc, right shoulder sprain-strain, lumbar spine sprain-strain, herniated lumbar disc and right hip sprain-strain. Her work status is temporary total disability. A note dated June 8, 2015 states the injured worker experiences efficacy from her medication regimen, which allows her to engage in activities of daily living. The note also states the injured worker experienced efficacy from physical therapy and limited relief from acupuncture. The following modalities, Ultrasound (guided cortisone injection) right wrist-hand (for therapeutic and analgesic purposes), physical therapy 2 times a week for 5 weeks for the right wrist-hand (to improve function, range of motion and previous efficacy) and an

epidural steroid injection at L4-L5 and L5-S1 (alleviate pain and improve function) are requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound-guided cortisone injection for the right wrist/hand: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist and Hand, Injection.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

Decision rationale: Regarding the request for corticosteroid injection to right wrist, California MTUS supports Injection of corticosteroids for various conditions such as carpal tunnel syndrome, de Quervain's syndrome, tenosynovitis, or trigger finger, and they consider an injection optional in moderate cases of tendinitis. Within the documentation available for review, there is no documentation of what the therapeutic target is within the risk, or of any rationale as to why ultrasound is needed. The patient has a pending MRI, which may better identify the pain generator such that the need for corticosteroid injection can be reevaluated after completion of the study. In light of the above issues, the currently requested corticosteroid injection to right wrist is not medically necessary.

Physical therapy 2 times a week for 5 weeks for the right wrist/hand: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist and Hand, Physical/Occupational Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of eight prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT

recommended by the ODG (which suggest 9 visits for wrist sprains) and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.

Epidural steroid injection at L4-L5 and L5-S1: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 47.

Decision rationale: Regarding the request for lumbar epidural steroid injection/selective nerve root block, 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, after failure of conservative treatment. Guidelines recommend that no more than one interlaminar level or two transforaminal levels should be injected in one session. Within the documentation available for review, there are recent subjective complaints or objective examination findings supporting a diagnosis of radiculopathy. Additionally, there is MRI which is recently performed in 6/2015 that demonstrates disc bulges at that targeted levels of this injection. The physical exam also demonstrates lower extremity hypoesthesia, consistent with lumbar radiculopathy. Given this, the currently requested lumbar epidural steroid injection is medically necessary.