

Case Number:	CM15-0191497		
Date Assigned:	10/05/2015	Date of Injury:	09/09/2002
Decision Date:	11/18/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	09/29/2015

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: Massachusetts

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 39 year old female who sustained an industrial injury on 9-9-02. A review of the medical records indicates she is undergoing treatment for pain in joint - shoulder, post laminectomy syndrome - cervical, thoracic-lumbar neuritis and radiculitis, post-laminectomy syndrome - lumbar region. Medical records (4-22-15 to 8-12-15) indicate ongoing complaints of neck pain, low back pain, left shoulder pain, and headaches. She rates her pain "6 out of 10" with the use of medications and "10 out of 10" without the use of medications. She describes the pain as "sharp, dull, throbbing, burning, aching, electricity, and pins and needles". She reports that the pain is "constant" and does not radiate. The physical exam (8-12-15) reveals decreased range of motion of the neck bilaterally, tenderness to palpation over the cervical spine with spasms. The lumbo-thoracic spine has decreased range of motion in "all planes" with tenderness to palpation of the lumbar paraspinous area and spasms. The straight leg raise is positive bilaterally. Bilateral lumbar radicular signs are noted. Pain is noted in the left subacromial bursa. Diagnostics have included x-rays of the cervical and lumbar spine, bilateral shoulders, bilateral scapulae, and the left wrist. MRIs of the cervical and lumbar spine, as well as the left shoulder and right knee have been completed. A CT scan of the cervical spine was completed, as well as a CT myelogram. EMG-NCV studies have been completed to bilateral upper and lower extremities. Treatment has included surgical procedures of the cervical and lumbar spine, a heating pad, H-wave unit, cervical epidural steroid injections at C7-T1, facet injections at C4-5 and C5-6, a left shoulder intra-articular injection, left subacromial bursa injection, medial branch block at C7 bilaterally, a home exercise program, and use of a rolling

walker. Other treatment requests have included a spinal cord stimulator, cervical radiofrequency ablation, a lumbar epidural steroid injection, and use of an electric scooter. It is unclear if these requested treatments were authorized. Effects of her symptoms on activities of daily living include requiring assistance with personal care, lifting only light weights, moderate headaches, difficulty concentrating, sleep disturbance, difficulty driving, difficulty with recreational activities and socialization, sexual problems, and difficulty with prolonged walking and sitting. The treatment recommendations include a fluoroscopy guided caudal epidural steroid injection, a left subacromial bursa injection with ultrasound, and a lumbosacral orthotic back support brace. The utilization review (9-22-15) indicates denial of the requested treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left subacromial bursa injection with ultrasound, quantity: 1: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, and Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Steroid injections.

Decision rationale: The claimant sustained a work injury in September 2002 when her neck snapped as she was lifting a rim and placing it on to a pallet. In January 2007 she underwent a lumbar fusion and has a history of a cervical spine fusion which was done in February 2005. An x-ray of the lumbar spine in September 2009 showed expected postoperative findings. An intra-articular left shoulder injection was done in January 2011. In May 2014 she underwent a left subacromial injection. In June 2014 there had been 40% pain relief. In April 2015 she underwent a second left subacromial bursa injection. She had a reported 80% pain relief after the procedure in follow-up. When seen, she was having headaches, neck pain, and low back pain. Pain was rated at 6-10/10. Physical examination findings included decreased cervical and lumbar spine range of motion with tenderness and muscle spasms. Straight leg raising was positive. There were bilateral lumbar radicular signs not further described. There was left subacromial bursa tenderness. No neurological examination was documented. Authorization is being requested for a repeat caudal epidural injection, repeat left subacromial injection, and replacement of the claimant's TLSO with the assessment referencing the presence of kinesiophobia. In terms of a repeat shoulder injection, a repeat injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response. The number of injections should be limited to three. In this case, the claimant has undergone two subacromial injection, both with benefit and with more improvement after the injection done in April. Although shoulder injections are generally performed without fluoroscopic or ultrasound guidance, there is some evidence that the use of imaging improves accuracy. A third, final subacromial injection meets the applicable coverage criteria and is considered medically necessary.

Caudal epidural steroid injection with fluoroscopy, quantity: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The claimant sustained a work injury in September 2002 when her neck snapped as she was lifting a rim and placing it on to a pallet. In January 2007 she underwent a lumbar fusion and has a history of a cervical spine fusion which was done in February 2005. An x-ray of the lumbar spine in September 2009 showed expected postoperative findings. An intra-articular left shoulder injection was done in January 2011. In May 2014 she underwent a left subacromial injection. In June 2014 there had been 40% pain relief. In April 2015 she underwent a second left subacromial bursa injection. She had a reported 80% pain relief after the procedure in follow-up. When seen, she was having headaches, neck pain, and low back pain. Pain was rated at 6-10/10. Physical examination findings included decreased cervical and lumbar spine range of motion with tenderness and muscle spasms. Straight leg raising was positive. There were bilateral lumbar radicular signs not further described. There was left subacromial bursa tenderness. No neurological examination was documented. Authorization is being requested for a repeat caudal epidural injection, repeat left subacromial injection, and replacement of the claimant's TLSO with the assessment referencing the presence of kinesiophobia. In the therapeutic phase guidelines recommend that a repeat epidural steroid injection 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. In this case, the degree and duration of any pain relief following the previous injection is not documented. The requested repeat lumbar epidural steroid injection is not considered medically necessary.

LSO (Lumbosacral Orthotic Back) support brace, quantity: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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 (Acute & Chronic), Lumbar supports and Other Medical Treatment Guidelines American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2007) Chapter 12: Low Back Disorders, p138-139.

Decision rationale: The claimant sustained a work injury in September 2002 when her neck snapped as she was lifting a rim and placing it on to a pallet. In January 2007 she underwent a lumbar fusion and has a history of a cervical spine fusion which was done in February 2005. An x-ray of the lumbar spine in September 2009 showed expected postoperative findings. An intra-articular left shoulder injection was done in January 2011. In May 2014 she underwent a left subacromial injection. In June 2014 there had been 40% pain relief. In April 2015 she underwent a second left subacromial bursa injection. She had a reported 80% pain relief after the procedure in follow-up. When seen, she was having headaches, neck pain, and low back pain. Pain was rated at 6-10/10. Physical examination findings included decreased cervical and

lumbar spine range of motion with tenderness and muscle spasms. Straight leg raising was positive. There were bilateral lumbar radicular signs not further described. There was left subacromial bursa tenderness. No neurological examination was documented. Authorization is being requested for a repeat caudal epidural injection, repeat left subacromial injection, and replacement of the claimant's TLSO with the assessment referencing the presence of kinesiophobia. Guidelines recommend against the use of a lumbar support other than for specific treatment of spondylolisthesis, documented instability, or post-operative treatment after a lumbar fusion. In this case, there is no documented spinal instability or other condition that would suggest the need for a lumbar orthosis and the claimant has not undergone a recent fusion. Lumbar supports have not been shown to have lasting benefit beyond the acute phase of symptom relief and prolonged use of a support may discourage recommended exercise and activity with possible weakening of the spinal muscles and a potential worsening of the spinal condition. The proper treatment for kinesiophobia would be physical therapy with instruction in a home exercise program. The requested lumbar support is not considered medically necessary.