

<b>Case Number:</b>	CM15-0029771		
<b>Date Assigned:</b>	02/23/2015	<b>Date of Injury:</b>	07/01/2001
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	01/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/17/2015

### 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, Hawaii  
 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 57 year old male, who sustained an industrial injury on 07/01/2001. He has reported cervical pain and left shoulder pain. The diagnoses have included cervical sprain/strain; cervical radiculitis/radiculopathy of the bilateral upper extremities; and left shoulder internal derangement. Treatment to date has included medications, chiropractic sessions, and physical therapy. Medications have included Norco, Gabapentin, Terocin patches, and topical compounded creams. A progress note from the treating physician, dated 01/07/2015, documented a consultation with the injured worker. The injured worker reported moderate to severe cervical pain associated with tingling and numbness radiating to the right upper extremity; pain is associated with headaches; and left shoulder pain that radiates up to the neck and to the left arm with weakness, numbness, and tingling that radiates down to the right hand. Objective findings included tenderness to palpation over the anterior aspect of the left shoulder, suprascapular muscles, and the acromion; pain on palpation over the spinous processes at C3 through T1; and cervical compression test is positive. The treatment plan has included request for prescription medications; cervical epidural steroid injection; and left shoulder intra-articular injection. On 01/21/2015 Utilization Review modified a prescription for a Cervical Epidural Steroid Injection C7-T1 with cath to C3-7, to Cervical ESI C7-T1 with catheter guidance; noncertified a prescription for Left Shoulder Intra-articular Injection; and modified a prescription for TENS Unit Hot/Cold Therapy rental X 3 months, to TENS unit x 30-day rental. The MTUS, ACOEM and the ODG were cited. On 02/11/2015, the injured worker submitted an application for IMR for review of a prescription for a Cervical Epidural Steroid Injection C7-T1 with cath to

C3-7; a prescription for Left Shoulder Intra-articular Injection; and a prescription for TENS Unit Hot/Cold Therapy rental X 3 months.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Cervical Epidural Steroid Injection C7-T1 with cath to C3-7: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines Page(s): 46.

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

**Decision rationale:** The patient presents with cervical pain and left shoulder pain. The current request is for Cervical Epidural Steroid Injection C7-T1 with cath to C3-7. The treating physician states, in a report dated 01/07/15, I am requesting authorization for the first cervical epidural steroid injection at the level of C7-T1 with catheter to C3 through C7 under fluoroscopy guidance based on the positive signs and symptoms of radiculitis/radiculopathy of the bilateral upper extremities. The signs of radiculopathy are progressing rapidly. (35B) The UR report dated 1/21/15 states, Certify cervical ESI C7/T1 with catheter guidance. The MTUS guidelines state. Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). In this case, the treating physician has documented bilateral upper extremity radiculopathy, has failed conservative treatment and has MRI findings of positive disc herniation at C7/T1. There is no record of a prior cervical epidural steroid injection having been administered. The current request is medically necessary and the recommendation is for authorization.

#### **Left Shoulder Intra-articular Injection: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205 and 212-214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 213. Decision based on Non-MTUS Citation ODG Online Shoulder Chapter Steroid injections.

**Decision rationale:** The patient presents with cervical pain and left shoulder pain. The current request is for Left shoulder intra-articular injection. The treating physician report dated 1/7/15 indicates that the patient is diagnosed with left shoulder internal derangement with MRI findings dated 8/8/13 revealing moderate coracoacromial impingement. The physician states, I am requesting authorization for the first left shoulder intra-articular injection under fluoroscopy guidance. The ACOEM guidelines page 213 recommend cortisone injections for the treatment of rotator cuff inflammation, impingement syndrome or small tears. The ODG guidelines states there must be a Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff

problems, except for post-traumatic impingement of the shoulder; 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). In this case, the patient has failed to improve with conservative treatments and has been diagnosed with impingement syndrome. The current request is medically necessary and the recommendation is for authorization.

**TENS Unit Hot/Cold Therapy rental x 3 months:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-116. Decision based on Non-MTUS Citation ODG Neck and Upper back chapter: Heat/cold applications.

**Decision rationale:** The patient presents with cervical pain and left shoulder pain. The current request is for TENS Unit Hot/Cold Therapy rental x 3 months. The treating physician states, I also strongly recommend Tens unit, hot/cold therapy, and neck collar to improve muscle spasms and range of motion of the upper extremities. Failure of conservative treatment including physical therapy and acupuncture has been documented. The MTUS Guidelines do support a one month trial of TENS. The criteria for the use of TENS states that there must be documentation of pain of at least three months, evidence that appropriate pain modalities have been tried and failed and a treatment plan including the specific short and long term goals of treatment with the TENS unit should be submitted. In this case, the treating physician has prescribed a trial of TENS for rental of 3 months. The MTUS guidelines do not recommend a 3 month TENS trial. The request also states that hot/cold therapy is also requested. Simple hot and cold packs are recommended by ODG, but rental of a Hot/Cold Therapy unit is not supported. The current request is not medically necessary and the recommendation is for denial.