

<b>Case Number:</b>	CM15-0031213		
<b>Date Assigned:</b>	02/24/2015	<b>Date of Injury:</b>	11/01/2012
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	01/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2015

### 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: Preventive Medicine, Occupational Medicine

### 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 29 year old female who sustained an industrial injury on November 1, 2012. The injured worker was diagnosed with cervical radiculopathy, shoulder sprain/strain and capsular rotator cuff repair. The injured worker underwent right shoulder anterior capsulorrhaphy and rotator cuff interval closure in April 2013. According to the primary treating physician's progress report on January 2, 2015 the injured worker continues to experience discomfort and tightness in the neck, achy burning with sharp shooting sensations in the right scapula and a right hip popping sensation from her hip to the right lower extremity. Current medications consist of Tramadol, Meloxicam, Effexor XR, Nuvigil, Bupropion and Buspirone. Treatment modalities consist of physical therapy, occupational therapy, chiropractic therapy, home exercise program, ice, modified work restrictions and medications. The injured worker is temporary total disability (TTD) working modified duties. The treating physician requested authorization for right C7-T1 Interlaminar Epidural Steroid Injection and physical therapy for the cervical spine, Qty: 7. On January 28, 2015 the Utilization Review denied certification for right C7-T1 Interlaminar Epidural Steroid Injection and physical therapy for the cervical spine, Qty: 7. Citations used in the decision process were the Medical Treatment Utilization Schedule (MTUS), Chronic Pain Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right C7-T1 Interlaminar Epidural Steroid Injection: 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 Epidural Steroid Injections section Page(s): 46.

**Decision rationale:** The MTUS Guidelines recommend the use of epidural steroid injections (ESIs) as an option for treatment of radicular pain. Radicular pain is defined as pain in dermatomal distribution with corroborative findings of radiculopathy. Research has shown that less than two injections are usually required for a successful ESI outcome. A second epidural injection may be indicated if partial success is produced with the first injection and a third ESI is rarely recommended. ESI can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The treatment alone offers no significant long-term functional benefit. Criteria for the use of ESI include radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, and failed conservative treatment. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medications use for six to eight weeks. The medical records indicate that the injured worker is suffering from cervical spine radiculopathy, however, the clinical findings have not been corroborated by imaging studies and/or electrodiagnostic testing. Cervical spine MRI dated 1/21/2015 does not support this request. The request for Right C7-T1 Interlaminar Epidural Steroid Injection is determined to not be medically necessary.

**Cervical Spine Physical Therapy, # 7: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**Decision rationale:** The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified; receive 9-10 visits over 8 weeks. The injured worker has been injured for over two years. She has had physical therapy previously. The expectation is that physical therapy is replaced by a home exercise program for continued rehabilitation. The medical reports do not indicate that the injured worker has had lasting benefit from physical therapy, and the need for additional therapy has not been established within the recommendations of the MTUS Guidelines. The request for Cervical Spine Physical Therapy, #7 is determined to not be medically necessary.