

<b>Case Number:</b>	CM15-0087142		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	05/24/2013
<b>Decision Date:</b>	06/19/2015	<b>UR Denial Date:</b>	04/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/06/2015

### 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: Arizona, California Certification(s)/Specialty: Family Practice

### 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 46 year old male, who sustained an industrial injury on May 24, 2013. He reported his body being jolted in a car accident. The injured worker was diagnosed as having cervical disc disease, cervical radiculopathy, post annular tear at cervical 5-cervical 6, left shoulder superior labral tear from anterior to posterior tear, lumbar disc disease, lumbar radiculopathy, and lumbar facet syndrome. Diagnostic studies to date have included MRI and x-rays. Treatment to date has included off work, activity modifications, physical therapy, chiropractic therapy, rest, a back brace, and medications including pain, muscle relaxant, proton pump inhibitor, and non-steroidal anti-inflammatory. On February 26, 2015, the injured worker complains of cervical spine pain and limited range of motion turning to the left. The pain was described as intense, stabbing, and shooting especially when driving. He complains of chronic, aching left shoulder pain. Associated symptoms include numbness during the day, tingling at night, swelling, loss of grip, and inability to use the arm. He complains of "man down" lumbar spine pain, which was described as shooting, aching, and stabbing. Associated symptoms include tightness, limited range of motion, locking, right leg numbness and tingling, and numbness of the foot, heel, and toe constantly. His neck, left shoulder, and lumbar spine pain was rated 8-9/10. The physical exam revealed a right antalgic gait, decreased cervical lordosis, moderate tenderness and spasm from the cervical paravertebral muscles to the bilateral trapezius muscles, and mildly decreased cervical range of motion. There was acromioclavicular joint and supraspinatus tenderness of the left shoulder and mildly decreased range of motion. The bilateral cervical 6 dermatomes had decreased sensation. There was decreased muscle strength of the bilateral elbow flexors (cervical 5, 6). The lumbar spine exam revealed diffuse paravertebral musculature tenderness, moderate lumbar 4-sacral 1 facet tenderness, positive seated and supine right straight leg raise, mildly decreased range of motion, and decreased sensation in the right

lumbar 4, lumbar 5, and sacral 1 dermatomes. There was decreased strength of the right big toe extensors (lumbar 5) and normal reflexes of the bilateral lower extremities. The treatment plan includes bilateral cervical 5-6 transfacet epidural steroid injection, right lumbar 5-sacral 1 & right sacral 1 transforaminal epidurals x2, and left shoulder corticosteroid injection under ultrasound guidance.

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

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

#### **Right L5-S1 & right S1 transforaminal epidural (times 2): Overturned**

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

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

**Decision rationale:** According to the guidelines, the criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks 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, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In this case, the claimant has over 8/10 pain and has failed conservative therapy. The claimant does have radiculopathy confirmed on exam and MRI. The request for the ESI injections are within the criteria of the guidelines and are medically necessary.

#### **Corticosteroid injection under ultrasound guidance: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment for Workers' Compensation (ODG-TWC) Shoulder Procedure Summary Online Version last updated 04/03/2015.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- shoulder and pg 33.

**Decision rationale:** According to the guidelines: Criteria for Steroid injections: Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for posttraumatic 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); Intended for short-term control of symptoms to resume conservative medical management; Generally performed without fluoroscopic or ultrasound guidance; Only one injection should be scheduled to start, rather than a series of three; A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option; The number of injections should be limited to three. In this case, the claimant does have a SLAP tear of the shoulder. There are impingement findings as well. The claimant has failed conservative therapy and the request for the shoulder injection is medically necessary.