

<b>Case Number:</b>	CM14-0121864		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	04/21/2003
<b>Decision Date:</b>	11/06/2014	<b>UR Denial Date:</b>	07/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2014

### 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. The expert reviewer is Board Certified in Pain Medicine and is licensed to practice in Minnesota. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 reported an injury on 05/18/2012. The mechanism of injury was not submitted for clinical review. The diagnoses included cervical myofascitis, right C6 radiculopathy, cervicogenic muscle tension headache, epicondylitis, radial tunnel syndrome, cubital tunnel syndrome, internal derangement of the wrist/hand, and De Quervain's syndrome. Previous treatments included medication and physical therapy. The diagnosis included x-rays, MRI, and EMG/NCV. Within the clinical note dated 07/09/2014 it was reported the injured worker complained of neck pain associated with headaches on the right, radiating down the arm with numbness in the fourth and fifth digit. She rated her pain 8/10 to 9/10 in severity. She complained of intermittent right wrist/thumb pain. She rated the pain 5/10 in severity. The injured worker complained of elbow pain rated 7/10 in severity. Upon physical examination the provider noted reflexes were normal at 2+ in the upper and lower extremities. There was a positive Finkelstein's test noted. The foraminal compression test was positive on the right lateral, neutral, and extension. The provider requested physical therapy for the right elbow, right wrist, right thumb, and a pain specialist consultation. The Request for Authorization was submitted and dated on 07/09/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**6 visits for physical therapy for the right elbow: Upheld**

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

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

**Decision rationale:** The request for 12 visits for physical therapy for the right elbow is not medically necessary. The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines allow for fading of treatment frequency plus active self-directed home physical medicine. The guidelines note for neuralgia and myalgia, 8 to 10 visits of physical therapy are recommended. There is a lack of documentation indicating the injured worker's prior course of physical therapy, as well as the efficacy of the therapy, including functional improvement. The number of sessions the injured worker has undergone was not submitted for clinical review. Therefore, the request is not medically necessary.

**6 visits for physical therapy for the right wrist and thumb:** Upheld

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

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

**Decision rationale:** The request for 12 visits for physical therapy for the right wrist is not medically necessary. The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines allow for fading of treatment frequency plus active self-directed home physical medicine. The guidelines note for neuralgia and myalgia, 8 to 10 visits of physical therapy are recommended. There is a lack of documentation indicating the injured worker's prior course of physical therapy, as well as the efficacy of the therapy, including functional improvement. The number of sessions the injured worker has undergone was not submitted for clinical review. Therefore, the request is not medically necessary.

**Pain Specialist consultation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, updated guidelines, Chapter 6, page 163

**Decision rationale:** The request for Pain Specialist consultation is not medically necessary. The California MTUS/ACOEM Guidelines state that a consultation is intended to aid in assessing the diagnosis, prognosis, therapeutic management, and determination in medical stability, and permanent residual loss and/or examinee's fitness to return to work. The medical necessity for the request was not warranted in the clinical documentation submitted. Additionally, the number of sessions the provider intended the injured worker to undergo was not submitted for clinical review. Therefore, the request is not medically necessary.

**3 cervical epidurals:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, Chronic Pain Treatment Guidelines.

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

**Decision rationale:** The request for 3 cervical epidurals is not medically necessary. The California MTUS Guidelines recommend epidural steroid injections as an option for the treatment of radicular pain, defined as pain in a dermatomal distribution with corroborated findings of radiculopathy. The guidelines note that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic study testing, initially unresponsive to conservative treatment, exercise, physical methods, NSAIDs, and muscle relaxants. There is a lack of imaging studies to corroborate the diagnosis of radiculopathy. There is a lack of documentation indicating the injured worker had been unresponsive to conservative treatment, including exercise, physical methods, and muscle relaxants. The request submitted failed to provide the treatment site. Therefore, the request is not medically necessary.

**Hand specialist consult for opinion on possible surgical intervention and/or cortisone injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, updated guidelines, Chapter 6, page 163

**Decision rationale:** The request for a Hand specialist consult for opinion on possible surgical intervention and/or cortisone injection is not medically necessary. The American College of Occupational and Environmental Medicine state consultation is intended to aid in the assessing the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and or examinee's fitness for return to work. The provider's rationale was not submitted for clinical review warranting the medical necessity for the request. Additionally the request submitted failed to provide the specific type of surgical intervention, or the treatment site of the injection. Therefore, the request is not medically necessary.

