

Case Number:	CM14-0124325		
Date Assigned:	08/08/2014	Date of Injury:	04/05/2010
Decision Date:	10/07/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	08/06/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 34-year-old female was reportedly injured on 4/5/2010. The mechanism of injury was noted as cumulative trauma. The claimant underwent a left carpal tunnel decompression on 5/14/2014. The most recent progress notes, dated 6/7/2014 and 7/10/2014, indicate that there were ongoing complaints of neck and shoulder pains with radiation to the left upper extremity. Physical examination demonstrated no signs of infection of the incision with mild edema, decreased cervical lordosis, tenderness, tightness and spasm to the paraspinal muscles, positive Spurling's sign, facet tenderness at C6-C7, decreased cervical range of motion, decreased sensation in the C6 and C7 dermatomes bilaterally, 5/5 motor strength, deep tendon reflexes 1+ left brachioradialis otherwise 2+ in the upper extremities bilaterally. MRI of the cervical spine, dated 5/7/2014, demonstrated broad midline disk protrusion resulting in flattening of the thecal sac with mild degree of central canal stenosis at C6-C7, left-sided uncovertebral bony hypertrophy, which is resulting in narrowing of the left neural foramen with abutment of the exiting left cervical nerve root at C5-C6, right paracentral disk protrusion resulting in mild degree of central canal stenosis at C3-C4. Diagnoses were cervical radiculopathy, cervical facet syndrome, cervical disk disease, left shoulder sprain/strain and left carpal tunnel syndrome status post carpal tunnel release. Previous treatment included physical therapy, chiropractic manipulation, home exercises, medications and cervical epidural steroid injections 2 years ago (procedure note was not available for this independent medical review). A request had been made for physical therapy left wrist x 12 (postop) and cervical epidural steroid injection, which were not certified in the utilization review on 7/1/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy Left wrist x 12 (Post-op): Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: MTUS postsurgical treatment guidelines support 3-8 visits of physical therapy over 3-5 weeks after a carpal tunnel release (endoscopic or open). The claimant underwent left carpal tunnel decompression on 5/14/2014. The current request for #12 sessions of physical therapy exceeds the guideline's allowable amount. As such, this request is not considered medically necessary.

Cervical Epidural Steroid Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (ESI).

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

Decision rationale: MTUS treatment guidelines support cervical epidural steroid injections when radiculopathy is documented on physical examination and corroborated by imaging and electrodiagnostic studies in individuals who have not improved with conservative treatment. Based on the clinical documentation provided, and considering the criteria for the use of epidural steroid injections as outlined in the MTUS, there is insufficient clinical evidence presented that the proposed procedure meets the MTUS guidelines. Specifically, there is no documentation of electrodiagnostic studies of the upper extremities confirming the diagnosis of cervical radiculopathy. As such, this request is not considered medically necessary.