

Case Number:	CM14-0073266		
Date Assigned:	07/16/2014	Date of Injury:	09/09/2010
Decision Date:	08/14/2014	UR Denial Date:	04/21/2014
Priority:	Standard	Application Received:	05/20/2014

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 and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 patient is a 67-year-old male with date of injury of 09/09/2010. The listed diagnoses per [REDACTED] dated 04/10/2014 are: 1. Arthropathy, not otherwise specified of the shoulder. 2. Cervical disk degeneration. 3. Shoulder region disorder, not otherwise specified. 4. Osteoarthritis, not otherwise specified of the upper arm. According to this report, the patient complains of right shoulder pain. He rates his pain an 8/10. The pain is characterized as aching and sharp that radiates to the right arm. He states that medications are helping. He tolerates his medications well. The patient shows no evidence of developing medication dependency. With his current medication regimen, his pain symptoms are adequately managed. His current medications include hydrocodone-acetaminophen and quazepam 15 mg. The examination shows the patient is well-developed, well-nourished, in no distress. The patient's gait is normal. Range of motion is restricted in the cervical spine. The right shoulder movement is restricted with flexion and adduction by pain. Neer's test is positive. There is tenderness upon palpation in the glenohumeral joint and right trapezius musculature. The left shoulder shows no limitations upon range of motion. Shoulder external rotation is 4/5 on the right and 5/5 on the left. Shoulder internal rotation is 3/5 on the right and 5/5 on the left. Sensory examination is decreased over the medial forearm and lateral forearm, on the right side. The utilization review denied the request on 04/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right C6-C7 transforaminal epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections Page(s): 46, 47.

Decision rationale: This patient presents with right shoulder pain. The treating physician is requesting a right C6-C7 transforaminal epidural steroid injection. The California Medical Treatment Utilization Schedule (MTUS) Guidelines page 46 and 47 on epidural steroid injections recommend this as an option for treatment of radicular pain, as defined by pain in a dermatomal distribution with corroborative findings in an magnetic resonance imaging (MRI). Furthermore, no more than two nerve root levels should be injected using transforaminal blocks. While the physical exam shows decreased sensation over the medial forearm and lateral forearm on the right side, the records do not show a recent or previous MRI of the cervical spine to corroborate radiating pain. Given the lack of a clear diagnosis of radiculopathy as evidenced by imaging studies. The requested treatment is not medically necessary and appropriate.

Continued acupuncture sessions for the right shoulder 1x8: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: This patient presents with right shoulder pain. The treating physician is requesting continued acupuncture sessions for the right shoulder times 8. The California Medical Treatment Utilization Schedule (MTUS) Guidelines for acupuncture states that it is used as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. In addition, MTUS states that an initial trial of 3 to 6 visits is recommended. Treatments may be extended if functional improvement is documented. The records show 5 acupuncture reports. The most recent of which was on 03/24/2014. In this report, the patient states that he has some movement in his shoulder; however, there is little change to his pain level. His range of motion is still very limited and rates his pain 8/10 to 9/10. In this case, the patient has trialed acupuncture with minimal benefit. Given the lack of functional improvement while utilizing acupuncture, the requested 8 additional visits is not medically necessary. The requested treatment is not medically necessary and appropriate.