

<b>Case Number:</b>	CM14-0204657		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	05/26/2001
<b>Decision Date:</b>	06/04/2015	<b>UR Denial Date:</b>	11/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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. 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, Hawaii  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 65 year old female who sustained an industrial injury on May 26, 2001. She has reported injury to the left upper extremity and has been diagnosed with cervical spondylosis. Treatment has included surgery, injection, and medications. Currently the injured worker had pain in the left upper extremity below the elbow. The treatment request included a cervical epidural injection C6-7 under sedation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical epidural injection at C6-7:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The patient presents with pain affecting the upper left extremity. The current request is for Cervical epidural injection at C6-7. The treating physician report dated

9/29/14 (11B) states, "I request a cervical epidural steroid injection to be performed with the purpose of reducing pain and inflammation, restoring ROM and thereby facilitating progress in more active treatment programs, avoiding surgery and based on the current ODG and MTUS Guidelines. Patient met all criteria for the use of epidural steroid injections." MTUS Guidelines do recommend ESIs as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. MTUS guidelines go on to state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The medical reports provided, do not show that the patient has received a previous ESI at the C6-7 level. In this case, while the patient presents with cervical spondylosis with pain radiating down the left upper extremity, there were no imaging and/or electrodiagnostic studies provided for review that corroborate the findings of radiculopathy. The current request does not satisfy the MTUS guidelines as outlined on page 46. Recommendation is for denial. The request is not medically necessary.

**Corticosteroid of the left wrist using ultrasound:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264.

**Decision rationale:** The patient presents with pain affecting the upper left extremity. The current request is for Corticosteroid of the left wrist using ultrasound. The requesting treating physician report was not found in the documents provided. A report dated 9/29/14 (11B) states, "She had surgery on the left thumb and left wrist and states the pain was better for two months and then flared up two months after surgery." The MTUS and ODG guidelines do not address the current request. The ACOEM guidelines chapter 11 page 264 does not recommend corticosteroid injections for non-specific wrist or hand pain. There is no documentation of carpal tunnel syndrome, tendonitis or tenosynovitis in the medical reports provided for review. In this case, while the patient presents with wrist pain, there is limited documentation of carpal tunnel syndrome or tenosynovitis in the reports provided, and a corticosteroid injection for non-specific wrist pain is not supported. Recommendation is for denial. The request is not medically necessary.

**Purchase of TENS unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation BlueCross/BlueShield, TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114.

**Decision rationale:** The patient presents with pain affecting the upper left extremity. The current request is for Purchase of TENS unit. The requesting treating physician report was not found in the documents provided. Per the MTUS guidelines, TENS units have no proven

efficacy in treating chronic pain and are not recommend as a primary treatment modality, but a one month home based trial may be considered for specific diagnosis of neuropathy, CRPS, spasticity, phantom limb pain, or Multiple Sclerosis. MTUS also quotes a recent meta-analysis of electrical nerve stimulation for chronic musculoskeletal pain, but concludes that the design of the study had questionable methodology and the results require further evaluation before application to specific clinical practice. There is no evidence in the documents provided that shows the patient has previously been prescribed a TENS unit for a one month trial as indicated by the MTUS guidelines. Furthermore, while a one month trial would be reasonable and within the MTUS guidelines, the purchase of a TENS unit without documentation of functional improvement is not supported. The current request does not satisfy the MTUS guidelines as outlined on page 114. Recommendation is for denial. The request is not medically necessary.