

Case Number:	CM15-0010427		
Date Assigned:	01/28/2015	Date of Injury:	08/01/2007
Decision Date:	03/30/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/19/2015

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: California
 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 47 year old female who sustained an industrial injury on 08/01/2007. Diagnoses include cervical herniated nucleus pulposus, cervical radiculopathy, chronic pain syndrome, multilevel thoracic degenerative disc disease, bilateral carpal tunnel syndrome, bilateral carpal tunnel syndrome release-date unknown. Treatment to date has included medications, and wrist splints. A physician progress note dated 11/13/2014 documents the injured worker has continued neck pain rated 6 out of 10 and radiates down both arms, right worse than left. She has headaches and pain in her left wrist and hand with numbness in digits 3-5 and spreads to digits 2 and 1 as it intensity. She wears bilateral wrist splints. There is pain rated 7 to 10 in the thoracic spine that radiates to her chest wall with associated numbness. She admits to urinary incontinence. On examination there is cervical paraspinal muscle tenderness, and range of motion is moderately limited in all planes. There is significant tenderness to palpation over the thoracic spine and in the right shoulder and wrists and hands bilaterally. Range of motion is decreased in the shoulders, elbows, wrists and fingers. Treatment requested is for cervical epidural steroid injection x 1 (unspecified level and laterality), functional restoration program evaluation x 1, and thoracic epidural steroid injection x 1 (unspecified level and laterality). On 12/22/2014 Utilization Review non-certified the request for cervical epidural steroid injection x 1 (unspecified level and laterality), and cited was California Medical Treatment Utilization Schedule (MTUS). The request for thoracic epidural steroid injection x 1 (unspecified level and laterality) was non-certified, and cited was California Medical Treatment Utilization Schedule (MTUS). The request for Functional restoration program evaluation x 1

was non-certified and cited was California Medical Treatment Utilization Schedule-Chronic Pain Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical epidural steroid injection x 1 (unspecified level and laterality): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs), page 47.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); however, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not clearly established here. Submitted reports have not adequately demonstrated any neurological deficits or significant findings of radiculopathy collaborated with imaging. The symptom complaints, pain level, clinical findings and pain medication dosing remained unchanged for this chronic injury. The patient continues to treat for chronic symptoms without report of flare-up, new injury, or acute change in clinical findings or progression in functional status. The Cervical epidural steroid injection x 1 (unspecified level and laterality) is not medically necessary and appropriate.

Thoracic epidural steroid injection x 1 (unspecified level and laterality): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs), page 46.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); However, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not provided here. Submitted reports have not demonstrated any radicular symptoms, neurological deficits or remarkable diagnostics to support the epidural injections. There is no report of acute new injury, flare-up, or red-flag conditions to support for pain procedure. Criteria for the epidurals have not been met or established. The Thoracic epidural steroid injection x 1 (unspecified level and laterality) is not medically necessary and appropriate.

Functional restoration program evaluation x 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (Functional Restoration Programs), pages 30-34, 49.

Decision rationale: The patient remains not working. Guidelines criteria for a functional restoration program requires at a minimum, appropriate indications for multiple therapy modalities including behavioral/ psychological treatment, physical or occupational therapy, and at least one other rehabilitation oriented discipline. Criteria for the provision of such services should include satisfaction of the criteria for coordinated functional restoration care as appropriate to the case; A level of disability or dysfunction; No drug dependence or problematic or significant opioid usage; and A clinical problem for which a return to work can be anticipated upon completion of the services. There is no report of the above as the patient has unchanged chronic pain symptoms and clinical presentation, without any aspiration to return to any form of work for this chronic injury as the patient has remained functionally unchanged, on chronic opioid medication without functional improvement from extensive treatments already rendered. There is also no psychological issue or diagnoses meeting criteria for functional restoration program. The Functional restoration program evaluation x 1 is not medically necessary and appropriate.