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| Case Number: | CM15-0013757 | | |
| Date Assigned: | 02/02/2015 | Date of Injury: | 05/03/2002 |
| Decision Date: | 03/18/2015 | UR Denial Date: | 12/22/2014 |
| Priority: | Standard | Application Received: | 01/23/2015 |

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 female patient, who sustained an industrial injury on 05/03/2002. A primary treating office visit dated 12/19/2014 reported subjective complaints of constant, moderate to severe cervical pain that was described as sharp. The pain was aggravated by sitting. There was also complaint of thoracic and lumbar pain both of which were aggravated by walking. In addition, she has pain in the left shoulder, left wrist and hand; left ankle and foot. Physical examination found cervical spine with plus two spasm, tenderness to the bilateral paraspinal muscle from C2-C7 and bilateral suboccipital muscles. A distraction test noted positive bialterally; shoulder depression test noted positive on the left and the left biceps reflex was decreased. The thoracic spine showed a plus three spasm with tenderness to the bilateral paraspinal muscles from T3-T8. The lumbar spine also with plus three spasm and tenderness to bilateral lumbar paraspinal muscles from L1 - S1 and multifidus. Kemp's test was positive bilaterally; straight leg raise test positive on the right and Yeoman's with positive bilaterall results. The right achilles reflex was decreased. her shoulders noted with spasm, tenderness to the left rotator cuff muscles and left upper shoulder msucles. Codman's test with positive results on the left. Speeds test with postive findigns on the left. Supraspinatous test was positive on the left and both Neers and Push Button tests were positive on the left. The patient's wrist, hands feet and ankles also noted with spasm, tenderness and the following positive findings; Bracelet, Finkelstein's and Varus all on left. The following diagnoses are applied; lumbar disc displacement without myeopathy; cervical disc herniation without myelopahty; bursitis and tendonitis of the left shoulder; left shoudler impingement; left carpal sprain/strain; left ankle

strain/sprain and thoracic sprain /strain. She is noted having had completed 6 session of physical medicine without evidence of any functional improvement. Additional therapy session were requested to include work hardening/conditioning for 10 visits. The patients work status reported being released to work on 12/19/2014 under restrictions until 02/19/2015. On 12/22/2014 Utilization Review non-certified a request that had been made a few times prior asking for one epidural steroid injection treating the cervical, thoracic,lumbar spine, shoulder, wrists and ankles; noting the CA MTUS Chronic Pain Epidural Steroid Injections was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI's Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections, p46 Page(s): 46.

Decision rationale: The claimant is more than 10 years status post work-related injury and continues to be treated for chronic widespread pain. She is undergoing additional therapy including work hardening/conditioning and there is reference to a return to work plan. The requesting provider documents lower extremity weakness with positive straight leg raising and decreased ankle reflex. Conservative treatments have included physical therapy without benefit. Criteria for the use of epidural steroid injections include that radiculopathy be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, the claimant's provider documents positive findings of radiculopathy on examination but there is no reported corroboration through objective testing as is required. Therefore, the criteria are not met and the requested epidural steroid injection is therefore not considered medically necessary.