

Case Number:	CM15-0116824		
Date Assigned:	06/25/2015	Date of Injury:	04/29/2013
Decision Date:	07/23/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/17/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 58-year-old female with an industrial injury dated 04/29/2013. The mechanism of injury is documented as a fall landing on her right hand, arm and shoulder resulting in pain from the level of the neck down into the hand. Her diagnoses included status post right shoulder arthroscopic SLAP repair, manipulation and lysis of adhesions; history of prior right shoulder arthroscopic rotator cuff repair, biceps tenodesis, subacromial decompression and distal clavicle excision; chronic right upper extremity pain and numbness, cervical degenerative spine disease and secondary neuro foraminal narrowing, right cervical radiculitis and chronic right wrist sprain/strain and triangular fibrocartilage tear. Prior treatment included surgery for rotator cuff tear, Spica splint, physical therapy, diagnostics and medications. She presents on 01/14/2015 with complaints of right shoulder, arm, wrist and hand symptoms. She was reportedly "laid off" and there was no availability of appropriate modified work duty. Physical exam noted decreased range of motion of the cervical spine with muscle guarding. There was no gross motor deficit on manual resistance testing but there was pain and submaximal effort. Light touch sensation was intact throughout the upper extremities. The plan of treatment included specialty evaluation or treatment with cervical spine injections as authorized. The injured worker was also to continue independent exercises and home therapy. The treatment request is for bilateral cervical epidural steroid injection at cervical 5-6 and transfer of care to pain management.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral cervical epidural steroid injection at C5-C6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for the use of epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Epidural steroid injections (ESIs).

Decision rationale: MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." There were no medical documents provided to conclude that a home exercise program is ongoing. Additionally, no objective findings were documented to specify the dermatomal distribution of pain, if any. MTUS further defines the criteria for epidural steroid injections to include: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. Although the treating physician has provided documentation of radiculopathy on exam, they have not provided documentation of radiculopathy on imaging studies and/or EMG at the requested cervical level. The documentation provided does not detail failure of conservative treatment as outlined in the guidelines. As such, the request for Bilateral cervical epidural steroid injection at C5-C6 is not medically necessary.

Transfer of care to pain management: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Office Visit.

Decision rationale: ODG states concerning office visits "Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible." The treating physician does not detail changes in subjective complaints and objective findings to warrant the pain management referral. The medical documentation provided does not detail the patient's pain level, nor is there documentation of failed conservative therapy. As such, the request for Transfer of care to pain management is not medically necessary at this time.