

<b>Case Number:</b>	CM15-0122855		
<b>Date Assigned:</b>	07/10/2015	<b>Date of Injury:</b>	01/19/2013
<b>Decision Date:</b>	08/05/2015	<b>UR Denial Date:</b>	06/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2015

### 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: Arizona, California  
 Certification(s)/Specialty: Family Practice

### 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 was a 53 year old female, who sustained an industrial injury, January 19, 2013. The injured worker previously received the following treatments Baclofen, Dilaudid, Gabapentin, Metamucil, Senna, Percocet, Orphenadrine, Docusate, Norflex and OxyContin, physical therapy for the left wrist and elbow and notice improvement, home exercise program and Voltaren. The injured worker was diagnosed with left cubital tunnel syndrome and carpal tunnel release on March 3, 2015, depression, left elbow nerve neuropathy, right total hip replacement, right hip revision, arthritis, degenerative disc disease of the lumbar spine and major depression. According to progress note of May 27, 2015, the injured worker's chief complaint was left wrist, left shoulder blade pain, right hip, mid and lumbar spine pain. The injured worker was left handed. The left wrist pain was aggravated by driving. The range of motion of the left wrist and elbow improved with physical therapy. The injured worker complained of occasional spasms in the right leg with weakness in the left hip and pain. The physical exam noted tenderness in the left scapula. There was tenderness in the left elbow at the surgical site as well as the left wrist surgical site. The left hand had pain with flexion and extension. The right hip did not have pain with active or passive range of motion. The treatment plan included pain management consultation and treat for epidural steroid injection and physical therapy for the left elbow and shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pain Management Consult and Treat for Lumbar ESI: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, chapter 7.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 47.

**Decision rationale:** According to the guidelines, the criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 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. In this case, prior MRI showed minimal abutment of L4-L5 spinal cord level. Most of the MRI is consistent with degenerative changes. Exam findings do not correlate with radicular symptoms. The request for ESI did not specify level. The request for pain management for ESI is not substantiated and not medically necessary.

**PT x6 for The Left Elbow/Wrist/Shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, 264, Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

**Decision rationale:** According to the ACOEM guidelines: Physical and Therapeutic Interventions are recommended for 1 to 2 visits for education. This education is to be utilized for at home exercises which include stretching, relaxation, strengthening exercises, etc. There is no documentation to indicate that the sessions provided cannot be done independently by the claimant at home. The claimant has undergone an unknown amount of prior therapy. Consequently, additional therapy sessions are not medically necessary.