

Case Number:	CM15-0066640		
Date Assigned:	04/14/2015	Date of Injury:	09/19/2013
Decision Date:	05/18/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/08/2015

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 61 year old female, who sustained an industrial injury on 9/9/13. She reported neck and shoulder injury. The injured worker was diagnosed as having cervical spine sprain/strain with left upper extremity radiation, status post left shoulder scope and left carpal tunnel syndrome. Treatment to date has included oral medications including narcotics, left shoulder surgery, chiropractic treatment, rest, physical therapy and home exercise program. Currently, the injured worker complains of neck and left upper extremity pain. Physical exam noted tenderness to palpation over anterior and lateral cervical spine with left upper extremity radiation. A request for authorization was submitted for bilateral epidural steroid injection and trial of interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transfacet ESI C5-C6, C7-T1: 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 ESI Page(s): 46-47.

Decision rationale: The patient presents with pain and weakness in her neck and upper extremity. The patient is s/p left shoulder arthroscopy in 2010. The request is for Bilateral C5-C6 and C7-T1 Transfacet Epidural Steroid Injections (ESI). None of the reports indicate that the patient has had previous ESI in the past. Per 02/24/15 progress report, examination of the cervical spine shows palpative tenderness with spasms over the cervical paravertebral musculature, trapezius muscles, and the cervical facet joints at C4 through T1 levels. Spurling sign is positive bilaterally. Axial head compression is positive bilaterally. Neck flexion is 20 degrees, extension is 50 degrees and rotation is 60 degrees. There is diminished sensation along the C5 and C7 dermatomes on the left side, as well as C6 and C8 dermatomes bilaterally. Diagnosis is cervical radiculopathy. MRI of the cervical spine shows multilevel degenerative disc disease with neural foraminal stenosis at C4-5 and C5-6 and there is a large 6-7mm disc herniation at C7-T1. EMG/NCV from 06/11/24 reveals moderate sensorimotor median neuropathy across the left wrist and suggestive of motor cervical or thoracic radiculopathy. Work status is unknown. The MTUS Guidelines page 46 and 47 on epidural steroid injections states that it is recommended as an option for treatment of radicular pain, as defined by pain in a dermatomal distribution with corroborative findings of radiculopathy in an MRI. MTUS also states, "There is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain." MTUS page 46 further states that "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." In this case, the patient primarily presents with neck and radiating left arm pain. The request is for bilateral ESI and the treater does not explain why right side needs to be treated as well. MRI describes disc herniation at C7-T1 with foraminal stenoses at C4-C6. Given the patient's left arm pain and disc herniation at C7-T1, ESI at this level may be reasonable but the request is for multi-level injections at bilateral levels. Radiculopathies on both sides are not documented with no described symptoms on the right side. Furthermore, MTUS generally does not support ESI of C-spine for radicular symptoms. The request IS NOT medically necessary.

Interferential unit trial 30 days: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The patient presents with pain and weakness in her neck and upper extremity. The patient is s/p left shoulder arthroscopy in 2010. The request is for Interferential Unit (IF unit) trial for 30 days. The patient has not tried IF in the past. Work status is unknown. MTUS guidelines page 118-120 states "Interferential Current Stimulation (ICS) Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). In this case, the treater requested "IF unit in order to increase circulation, decrease inflammation and

reduce the need for pain medication." The treater documents that the patient has failed conservative treatment including physical therapy, chiropractic treatment, medications and home exercise program "with no improvement." Documentation to support MTUS criteria had been met. The request for a month's trial IS medically necessary.