

Case Number:	CM14-0216053		
Date Assigned:	01/06/2015	Date of Injury:	02/06/2012
Decision Date:	10/13/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	12/24/2014

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: Emergency 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:

This is a 56-year-old female worker who was injured on 2-6-12. The medical records reviewed indicated the injured worker (IW) was treated for right rotator cuff syndrome and myofascial syndrome, shoulders. The progress notes (7-14-14 to 10-22-14) indicated the IW had aching pain in the lateral aspect of the right shoulder and upper trapezial symptoms and neck symptoms. On physical examination (7-14-14 and 10-22-14 records), the IW had tenderness in the bilateral upper trapezius, deltoid and the lateral biceps. Range of motion (ROM) was restricted in the neck, especially in forward flexion. ROM was symmetrical in the shoulders with no pain with resisted abduction or forward flexion. Treatments have included right rotator cuff repair, physical therapy and home exercise. A Request for Authorization asked for cervical ESI (epidural steroid injection) and consult - pain management 99214. The Utilization Review on 12-23-14 non-certified the request for cervical ESI (epidural steroid injection) because the documentation lacked clinical indications for the treatment; the requested consult - pain management was non-certified because the ESI was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical ESI: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The requested Cervical ESI is not medically necessary. Chronic Pain Medical Treatment Guidelines, p. 46, Epidural steroid injections (ESIs) note the criteria for epidural injections are: 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). The injured worker has aching pain in the lateral aspect of the right shoulder and upper trapezial symptoms and neck symptoms. On physical examination (7-14-14 and 10-22-14 records) the IW had tenderness in the bilateral upper trapezius, deltoid and the lateral biceps. Range of motion (ROM) was restricted in the neck, especially in forward flexion. ROM was symmetrical in the shoulders with no pain with resisted abduction or forward flexion. The treating physician has not documented physical exam evidence indicative of radiculopathy such as deficits in dermatomal sensation, reflexes or muscle strength; nor positive imaging and/or electrodiagnostic findings indicative of radiculopathy. The criteria noted above not having been met, Cervical ESI is not medically necessary.

Consult - Pain Management: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 11th edition (web), 2014, Neck and Upper Back (acute & chronic), Office Visits.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Introduction.

Decision rationale: The requested Consult - Pain Management, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 1, Part 1: Introduction, states "If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary." The injured worker has aching pain in the lateral aspect of the right shoulder and upper trapezial symptoms and neck symptoms. On physical examination (7-14-14 and 10-22-14 records) the IW had tenderness in the bilateral upper trapezius, deltoid and the lateral biceps. Range of motion (ROM) was restricted in the neck, especially in forward flexion. ROM was symmetrical in the shoulders with no pain with resisted abduction or forward flexion. The treating physician did not adequately document the medical necessity for this consult nor how the treating physician is anticipating this consult will affect treatment. The criteria noted above not having been met, Consult - Pain Management is not medically necessary.