

Case Number:	CM13-0002356		
Date Assigned:	01/10/2014	Date of Injury:	10/10/2006
Decision Date:	05/29/2014	UR Denial Date:	07/05/2013
Priority:	Standard	Application Received:	07/22/2013

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. The expert reviewer is Board Certified in Osteopathic Manipulative Medicine and is licensed to practice in Arizona. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 61 year old male with a complaint of neck pain following an injury that occurred on October 10, 2006 with a mechanism of injury of work-related lifting activities. Requesting physician's progress report dated 12/17/13 documents 'Sx's (symptoms) unchanged. Continued complaint of positive pain and stiffness to neck. Positive tenderness and sore spot to left side of neck especially with overhead movement with bilateral arms. Range of motion limited to neck.' On physical exam, the patient has positive left paraspinal tenderness to palpation, a positive left spurling's test and given the diagnosis a left foraminal stenosis C5-6 left radiculopathy. Cervical MRI dated January 16, 2013; Impression: straightening of the normal cervical lordosis; decreased disk height, degenerative marrow changes with anterior and posterior osteophytes noted at C5-6 and C6-7 levels. There is associated mild spinal stenosis and moderate bilateral foraminal narrowing at these levels; 1 mm central disk protrusions noted at the C3-4 and C4-5 levels, which abut, but do not compress the ventral aspect of the cervical spinal cord at these sites; mild to moderate narrowing seen involving the left C4 and Left C5 neural foramina'.

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL EPIDURAL STEROID INJECTION C5-6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174,181,Chronic Pain Treatment Guidelines Epidural steroid injections (ESIS) Page(s): 46.

Decision rationale: Per page 174, cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. On Table 8-8 on page 181, it states that 'Epidural injection of corticosteroid to avoid surgery (D)' is optional. It is recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI (epidural steroid injections); this is in contradiction to previous generally cited recommendations for a "series of three" ESI's. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. 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 is little information on improved function. Patient's EMG / NCV results dated Jun 19, 2013 states 'No electrical evidence of a cervical radiculopathy or brachial plexopathy affecting the C5 through T1 lower motor nerve fibers of the left upper extremity or the cervical paraspinals'. It goes on to state, 'Please note that annular discogenic tears can refer pain to an extremity without resulting in frank axonal compression on the exiting motor nerve roots and corresponding normal electro diagnostic studies'. Because the MTUS guidelines states that 'Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)' 'corroborative findings of radiculopathy' are not documented. Therefore the request is not medically necessary and appropriate.

CERVICAL EPIDURAL STEROID INJECTION C6-7: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174,181,Chronic Pain Treatment Guidelines Epidural steroid injections (ESIS) Page(s): 46.

Decision rationale: Per page 174 cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. On Table 8-8 on page 181, it states that 'Epidural injection of corticosteroid to avoid surgery (D)' is optional. It is recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI (epidural steroid injections) this is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second

epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. 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 is little information on improved function. Patient's EMG / NCV results dated June 19, 2013 states 'No electrical evidence of a cervical radiculopathy or brachial plexopathy affecting the C5 through T1 lower motor nerve fibers of the left upper extremity or the cervical paraspinals'. It goes on to state 'Please note that annular discogenic tears can refer pain to an extremity without resulting in frank axonal compression on the exiting motor nerve roots and corresponding normal electro-diagnostic studies'. Because the MTUS guidelines states that 'Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)', corroborative findings of radiculopathy' are not documented. Therefore the request is not medically necessary and appropriate.