

Case Number:	CM13-0029502		
Date Assigned:	11/01/2013	Date of Injury:	09/24/2010
Decision Date:	02/13/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	09/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and is licensed to practice in District of Columbia. 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 physician 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 54yo male pt who suffered an injury on Sept 24, 2010. Pt (patient) was climbing up a hydro truck and had dragged a hydro hose one week prior to this episode. Pt underwent C4-5 fusion with C3-4, C5-6 junction level pathology, s/p (status post) right carpal tunnel release, right shoulder impingement r/o rotator cuff pathology, lumbar discopathy with radiculitis, left knee lateral meniscus with baker's cyst and chondromalacia patellae. On Sept 24, 2010, [REDACTED], physical medicine and rehabilitation (PMR), saw pt and did not find acute cervical radiculopathy in BUE (Bilateral upper extremities), but did note bilateral ulnar neuropathy at the elbows without evidence for carpal tunnel syndrome. Pt had, on Mar 23, 2011, a right carpal tunnel release by [REDACTED]. Pt had an MRI of the spine on June 11, 2011 showing disc protrusions at L4-5 and L5-S1 with exiting nerve root compromise at L4-5 and L5-S1. In June 2012, pt reported left knee pain. Pt had an MRI of the cervical spine on Jul 7, 2012 noting central canal stenosis on C3-4 and C5-6. On Nov 9, 2012, pt had persistent neck pain and saw [REDACTED], orthopedics. He did not feel that any surgical intervention was warranted. On Feb 22, 2013 [REDACTED] did an anterior cervical microdiscectomy, and fusion. On June 6, 2013 pt saw [REDACTED], working for [REDACTED], for neck and back complaints he was noted to have motor deficits and some sensory loss. He was instructed to have an EMG/NCV of the bilateral upper and lower extremities to evaluate persistent numbness. On Aug 15, 2013 pt saw [REDACTED] after pt had undergone a successful cervical procedure, with some chronic cervicalgia. He had L5-S1 dysesthesia in the lower extremities. Following this, on Sept 10, 2013, pt was given naproxen, flexeril, Zofran, omeprazole, Medrox patch, to treat persistent sx (symptoms). On Oct 22, 2013 pt was seen for persistent symptoms. Over 1000 pages of clinical documentation were reviewed and none demonstrate a req

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain management consult for possible lumbar epidural steroid injection (LESI): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation ACOEM for Independent Medical Examination and Consultations regarding Referrals, Chapter 7, pg 127

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 39, 46, 103 and 110.

Decision rationale: This pt had persistent neck pain and back pain despite multiple surgical interventions, as well as ongoing medical management for chronic pain. None of the clinical documentation provided demonstrated that the practitioners actually recommended this therapy modality for assisting this pt's symptoms. However, as per MTUS guidelines: 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 None of this is clearly documented by the documentation provided. Neuro imaging was performed prior to surgical intervention. An EMG/NCV test was ordered following surgery but no results were able to be reviewed. Therefore, this is not medically indicated for this patient.