

Case Number:	CM13-0040456		
Date Assigned:	12/20/2013	Date of Injury:	10/10/2012
Decision Date:	02/25/2014	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	10/29/2013

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 Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California, Maryland, Florida, and Washington DC. 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:

The patient is a 50-year-old male who sustained an industrial injury on 10/10/2012 when he was involved in a motor vehicle accident while performing the duties of an aircraft worker. The patient states that he was standing up counting parts while on a picker, approximately 15-20' in height when the vehicle was rear ended. Upon impact, the patient was forcefully thrust backwards at which time he reached with both arms in an attempt to steady himself, after which he was forcefully thrown forwards and his mid back struck the steering wheel and his left leg buckled. The patient continued to work for another half hour until he began to experience pain in his neck, left shoulder and back. After reporting the injury to his supervisor the patient was offered medical care however he chose to continue to work until the end of his shift. The patient was referred by his employer to [REDACTED] where he was evaluated and x-rays were taken of his neck and back. Medication was prescribed and he was placed on temporary total disability. The patient subsequently developed radiation of pain into the left arm with associated numbness and tingling in the left hand, affecting all of the digits. He also began to experience radiation of pain into his left lower extremity extending to the heel. The patient was prescribed physical therapy, which the patient felt did not significantly relieve his pain. A cervical MRI dated 1/4/2013 documented mild left C4-5 neural foraminal stenosis and bilateral C5-6 neural foraminal stenosis with no other abnormalities. On 10/1/2013 the patient complained of restricted cervical range of movements in all directions. There was weakness of the biceps flexion in the left upper extremity; left C5-6 sensations were reduced. The patient is currently diagnosed with cervical radiculopathy. He has been treated with medications, traction therapy-which was not helpful, and physical therapy. The patient has a history of smoking, obesity, diabetes and being hypertensive. In the most recent medical report dated 10/1/13 the patient

complains of neck pain with numbness and tingling on the left side radiating in the left upper extremity in the sensory dermatomes corresponding to C5 and C6. Injured worker has undergone 2 course of PT and has had traction therapy for the neck which was not helpful. Current medications include Lisinopril, Flexeril, Vicodin, Etodolac, Methocarbamol. Upon exam, cervical spine shows tenderness; with anterior flexion of 40 degrees; with pain noted when neck is flexed anteriorly; with extension of 40 degrees with pain, left lateral rotation of 40 degrees with pain; with weakness on the biceps flexion on the left upper extremity *MRI of the cervical spine last 1/14/13 showed mild stenosis of the left C4-5 foramen, moderate stenosis of left C5-6 and mild stenosis of right C5-6 foramina; with no evidence of cord compression or focal disc protrusion, no evidence of instability and no abnormal signal within the spinal cord. Requesting for. Cervical Epidural Steroid Injection, Left C7-T1 Under Fluoroscopy and Anesthesia x1 62310, 00600, 77003 The current diagnosis is cervical radiculopathy. A request was made for a cervical ESI at left C7-T1 under fluoroscopy and anesthesia. Previous treatment is comprised of medications, Traction Therapy that was not helpful, and PT. A cervical MRI by [REDACTED] on 01/14/13 was negative for the C7-T1 level. He last had PT in 05/2013. He had a recent EMG/NCV study on week prior to the 10/01/13 evaluation but the results were not disclosed. He presented on 10/01/13 with left-sided neck pain graded 7/10 on VAS; the pain radiated to the left upper extremity and was associated with numbness over the left C5 and C6 dermatomes. Medications at that time included lisinopril-hydrochlorothiazide, Flexeril, Vicodin, etodolac, and methocarbamol. Cervical findings included painful ROM (40 degrees flexion, extension, and left lateral rotation), weakness on left biceps flexio

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Epidural Steroid Injection, Left C7-T1 under Fluoroscopy and Anesthesia:

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 Chronic Pain Medical Treatment Guidelines Epidural Steroid Injection (ESI),. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC-Pain (Chronic) Epidural steroid injection; and McKesson InterQual Guidelines.

Decision rationale: The Physician Reviewer's decision rationale: The provider has recommended in his treatment plan the inclusion of "an interlaminar cervical ESI at C7-T1 with catheter directed at left C5-C6 amongst other things. However, there is no currently recorded sensory deficit over the left C7-T1 dermatome, testing for Spurling's maneuver, and electro diagnostic or radiographic evidence of nerve root pathology at left C7-T1 to justify a cervical ESI at this level. There is also no mention of any significant anxiety that warrants sedation for the requested injection. Based on the aforementioned points, the medical necessity of cervical ESI at left C7-T1 under fluoroscopy and anesthesia cannot be validated at this time using the McKesson Interqual guidelines which stipulates: CERVICAL epidural steroid injections for

MILD TO MODERATE PAIN are medically necessary when the following are ALL true: (1) the pain is unilateral, in a nerve root