

Case Number:	CM13-0041227		
Date Assigned:	02/03/2014	Date of Injury:	06/06/2002
Decision Date:	04/28/2014	UR Denial Date:	09/12/2013
Priority:	Standard	Application Received:	10/11/2013

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 Occupational Medicine and is licensed to practice in California, Colorado, Michigan, Pennsylvania, and Texas. 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:

The patient is a 52 year old female who was injured on 06/06/2012 while assisting other employees moving a garbage compactor. As they attempted to lift the garbage compactor with a board, she felt immediate pain in her low back. She developed pain and numbness in her buttock radiating down to her knees and down to her calves. Prior treatment history has included PT, aqua therapy, and psychotherapy. The patient has had medication therapy including Flector, cyclobenzaprine, Butrans, Venlafaxine, lisinopril and atenolol. The patient underwent two lumbar spine surgeries, most recently L5-S1 fusion on 03/07/2007. On May 27, 2011, the patient underwent a cervical epidural steroid injection. She reported more than 50% decrease in pain in the neck and right upper extremity. She also reported improvements in range of motion of the cervical spine and overall improvement in quality of life. This 50% reduction of pain lasted approximately six weeks and then gradually wore off but continued to provide approximately 30% decrease in pain for the remaining additional three month. Her last CESI performed on 02/05/2013 and she received approximately 80% relief in her pain for a couple of months and then it gradually settled to 50% and most recently 45%. Diagnostic studies reviewed include MRI of the lumbar spine performed on 09/17/2013 revealed L5-S1 showed chronic spondylosis and 1.5 cm anterolisthesis. At L4-5, there is severe arthritis of the facets and bilateral foraminal stenosis. MRI of the cervical spine performed on 03/18/2009 revealed mild decreased disk height, small anterior and posterior osteophytes. With 2 mm diffuse disk bulges notes at the C4-5 and C5-6 levels which do not about the cervical spinal cord. No nerve root compression is identified; straightening of the normal cervical lordosis which may be secondary to patient positioning or muscle spasm. MRI of the lumbar spine with and without contrast performed on 03/18/2009 revealed the patient is status post low back surgery with bilateral laminectomy defects and pedicle screw tracts noted at L5 and S1. There is marked decreased

disc height, disc desiccation, with Grade II spondylolisthesis noted at the L5-S1 level. There is associated moderate to marked cephalocaudad narrowing involving the L5 neural foramina bilaterally. EMG of the lower extremity performed on 09/27/2007 revealed chronic left L5 and acute left S1 radiculopathy. Office note dated 10/03/2013 indicated the patient continues to have neck and low back pain. She states that her neck pain has returned to the baseline. She reports neck pain radiating into bilateral upper extremities, right greater than left. She notes numbness and tingling in digits 1-3 bilaterally. She notes that her pain is currently 8.5/10 on VAS. Objective findings on exam revealed range of motion is limited to 20 degrees flexion, 5 degrees extension and 1 degree lateral bending bilaterally. Sensation to light touch is reduced in C6, C7 and C8 dermatomes on the right when compared to the left side. She has positive Spurling's on right and motor strength is 4/5 with elbow flexion and extension bilaterally. The remainder of motor strength is intact for bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL EPIDUROGRAM, INSERTION OF CERVICAL CATHETER, FLUOROSCOPIC GUIDANCE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: According to CA MTUS guidelines, injections should be performed using fluoroscopic for guidance; however, since the associated request for cervical ESI is not medically necessary at this time, the request for cervical epidurogram, insertion of cervical catheter, fluoroscopic guidance is not medically necessary as it is associated with significant complications. See guidelines above

IV SEDATION: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: As the associated request for cervical ESI is not medically necessary at this time, the request for IV sedation is not medically necessary.

CERVICAL EPIDURAL STEROID INJECTION C4-5, C5-6, CERVICAL MYELOGRAPHY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: According to the CA MTUS guidelines, ESIs is recommended for as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The medical records document the patient was complaining of neck pain that radiated to the upper extremity more on the right than the left side with numbness in her 1-3 digits. On physical examination, the patient had limitation of neck movement. Sensation to light touch was reduced in C6, C7 and C8 nerve roots of the right upper extremity. There was positive Spurling's on right and motor strength was 4/5 with elbow flexion and extension bilaterally. There is documentation that a prior trial of cervical ESI in February 2013 resulted in more than 80% relief for 2 months. The last MRI of cervical spine was dated 03/18/2009 and reported small anterior and posterior osteophyte, with 2 mm diffuse disk bulges notes at the C4-5 and C5-6 levels which do not about the cervical spinal cord. No nerve root compression was identified. In summary, there are subjective and objective findings consistent with radiculopathy, but there is no recent cervical MRI available for review that correlates with subjective and objective findings to support the findings consistent with radiculopathy. The last MRI showed mild 2 mm disk bulges and no nerve root compression at the proposed levels. Thus, the request is not medically necessary.