MAXIMUS Federal Services

Case Number:	CM13-0044899		
Date Assigned:	02/03/2014	Date of Injury:	07/15/2011
Decision Date:	04/29/2014	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 an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 61 year old female who was injured on 07/15/2011. The mechanism of injury is unknown. Prior treatment history has included Prilosec, Anaprox, and Robaxin. Diagnostic studies reviewed include MRI of the cervical spine without contrast performed on 09/04/2013 revealed: 1. A reversal of the normal cervical lordosis is present 2. At the C6-7 disc space, there is now evidence of a broad-based 3 mm left paracentral and lateral subligamentous extruded disc herniation which has extended both superiorly and inferior to disc level for a total length of 7 mm and there is significant attenuation of the distal lateral recess and hypertrophic change of left uncovertebral joint with persistent moderate left foraminal stenosis is present. 3. At C5-6 disc space, there is a 3 mm broad base bulge in the annulus, lateral spondylosis, and hypertropic change of right uncovertebral joint with minimal spinal stenosis and attenuation of the anterior subarachnoid space, and there is moderate right and minimal left foraminal stenosis, findings which are relatively stable in comparison to the previous study. 4. At the C4-5 disc space, there is a 2 mm bulge in the annulus and broadening of the posterior longitudinal ligament with partial attenuation of the anterior subarachnoid space ventral to the cord without displacing the cord. There is no significant spinal stenosis. A quite capacious spinal canal is present. 5. At C3-4 disc space, there is a minimal 1-2 mm anterolisthesis and bulge in the annulus. There is hypertrophic change of uncovertebral joints with minimal right foraminal stenosis. X-ray of the cervical spine with flexion and extension views performed on 12/18/2013 revealed curve reversal without degenerative changes, disc space abnormality and spur formation also noted. PR2 dated 04/13/2014 written notes are illegible. The patient is diagnosed with sagittal plane instability. She has cervical degenerative disc disease with radiculopathy and herniated nucleus pulposus. It is recommended the patient has surgery if conservative care does not help. She is being referred for a transforaminal epidural steroidal injection on the left C6-C7, physical therapy, and she is

going to try Gabapentin again. She is to get flexion and extension x-rays to ascertain the stability of the cervical spine, and she will return to clinic in a few weeks. PR2 dated 01/20/2014 documented the patient to present with complaints of continuous neck pain as well as mid back pain. Objective findings revealed positive muscle joint pain, lower back pain and upper back pain. Examination of the cervical spine revealed decreased range of motion with flexion at 30 degrees, extension at 10 degrees, bilateral rotation at 60 degrees, and bilateral lateral flexion at 30 degrees. There is tenderness to the paraspinals and trapezius muscles, left greater than right. There is normal strength and sensation 5/5 on the right at C5, C6, C7 and C8 but on the left, there is decreased strength and sensation 4/5 at C5, C6, C7, and C8. There were 2+ deep tendon reflexes bilaterally at brachioradialis and triceps. The patient is diagnosed with multilevel disc disease with disc herniation and loss of alignment; loss of lordotic curvature with actual kyphosis and osteophytes; left parascapular myalgia and non-industrial multiple sclerosis. The patient is to continue exercises at home and stretching, and I would like to refer her to pain management for possible cervical epidural steroid injection, as soon as possible as they. PR2 dated 01/13/2014 documented the patient has gone to six sessions of physical therapy, which included traction, exercises, strengthening, TENS which makes her muscles relax, which all helped her neck pain though she still has some left upper extremity pain. The physical therapist, she states, is requesting more sessions of physical therapy. Objective findings on exam revealed 45 degrees of right rotation, 60 degrees of left rotation, 30 degrees of le

IMR ISSUES, DECISIONS AND RATIONALES

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

THREE (3) TRANSFORAMINAL EPIDURAL STEROID INJECTIONS AT LEFT C6-7: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESIs)..

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

Decision rationale: According to the MTUS Guidelines Criteria for the use of Epidural Steroid Injections, current guidelines recommend no more than 2 ESI (Epidural Steroid Injections). The request for three (3) ESI's (Epidural Steroid Injections) exceeds the maximum allowed. In the absence of documented guidelines not met, the request for three (3) transforaminal epidural steroid injections at left C6-C7 are not medically necessary and appropriate.