

Case Number:	CM13-0048590		
Date Assigned:	03/28/2014	Date of Injury:	08/05/2011
Decision Date:	07/09/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	11/06/2013

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 Neuromuscular/Neurology, 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 52-year-old who sustained a work-related injury on August 5, 2011. Subsequently she developed but chronic neck pain, right hand pain and left knee pain. The patient underwent an EMG (electromyogram) nerve conduction studies performed on September 11, 2012 which demonstrated the symmetric distal axonal motor polyneuropathy. There was no evidence of radiculopathy or focal neuropathy. A lumbar MRI was performed at the September 2, 2012 which demonstrated degenerative disc disease and facet arthropathy, nor foraminal narrowing at L2-L3 and L4-L5. The patient underwent cervical MRI performed on September 8, 2012 which demonstrated degenerative disc disease with facet arthropathy nor foraminal narrowing at C3-C4 and C4 C5, as severe bilateral neural foraminal narrowing at the level of C7-T1. The patient attended an orthopedic consultation on March 6, 2013, the patient was complaining of right wrist and hand pain. She was given a brace for the wrist. The pain was rated 8/10. The patient have some benefit from acupuncture and physical therapy. Her nerve conduction study performed on 2012 demonstrated right carpal tunnel syndrome. The patient continued to have chronic neck pain. According to the note of September 13, 2013, the patient was complaining to ongoing neck and low back pain with a severity is rated 6/10. Wearing a soft collar did help. She was taking Norco, Norflex, temazepam, Medrox batches. These medications helped with pain and function. Her physical examination demonstrated the cervical tenderness with reduced range of motion, decreased sensation in the territory of C7 and C8 dermatome a on the left and the L5 dermatome on the right. She has mild weakness and the left triceps and interossei. The patient was diagnosed with cervical radiculopathy, chronic low back pain, possible lumbar radiculopathy, multilevel disc herniation of the lumbar spine, multilevel disc herniation of the cervical spine with severe stenosis. The provider requested authorization for epidural steroid injections at the level of C6-C7 and C7-T1.

IMR ISSUES, DECISIONS AND RATIONALES

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

INFEROLAMINAR ESI AT C6-C7 AND C7-T1: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

Decision rationale: According to the Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines, 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. Epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit, however there is no significant long term benefit or reduction for the need of surgery. The patient clinical and MRI finding are suggestive of low cervical radiculopathy. An epidural injection is justified. However it should cover one level and not multiple levels. The patient clinical and objective findings are more pointing toward a C7-T1 radiculopathy. The request for a inferolaminar ESI at C6-C7 and C7-T1 is not medically necessary or appropriate.