

Case Number:	CM13-0055017		
Date Assigned:	12/30/2013	Date of Injury:	05/22/1984
Decision Date:	03/18/2014	UR Denial Date:	09/19/2013
Priority:	Standard	Application Received:	10/25/2013

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 Orthopedic Surgery and is licensed to practice in 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 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 was a 65-year-old male who sustained unspecified injury on 05/22/1984. The patient underwent a CT of the cervical spine on 10/31/2011 which had an impression of the patient was status post anterior cervical fusion at C4 through C7 with a screw plate at C5 through C7, question fracture of screw plate between the C5 and C6 screws; degenerative changes noted at the other levels including C2-3, C3-4, and C7-T1 with mild anterolisthesis of C7 on T1 which appeared to be degenerative and associated with facet arthropathy; uncovertebral and facet degenerative changes contribute to multilevel foraminal stenosis particularly on the left at the level of C3-4. The patient underwent an MRI of the cervical spine on 05/30/2013 which noted a change from the prior CT as a posterior spur/bony protuberance at C4-5 impinging on the right aspect of the thecal sac and possibly impinging on the spinal cord. It was additionally noted the patient underwent facet injections on 03/09/2012 with poor outcome. The patient was evaluated on 09/26/2013 which had findings of cervical pain radiating into the neck, right arm and right shoulder. The physical exam noted the patient had decreased range of motion in the cervical spine and absent watch reflexes. His physical examination also noted the patient had motor sensory examination which revealed a positive nerve tension sign on the left and right.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient transforaminal injection at C8: 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: The request for outpatient transforaminal injection at C8 is non-certified. The documentation submitted for review indicated the patient had a fusion from C4 through C7 and had not responded to initial physical therapy and was requesting authorization for medial branch block and then rhizotomy if helpful for his cervical pain and headache. The California MTUS Guidelines recommend the use of epidural steroid injections for patients with documented radiculopathy as corroborated by imaging studies and physical examination. The documentation submitted for review did not indicate the patient had radiculopathy at the C8 level nor was there imaging studies to corroborate the findings. Furthermore, the plan indicated the patient was requesting authorization for a medial branch block and rhizotomy if helpful for his cervical pain and headache. The plan did not indicate an epidural steroid injection as part of the treatment. Given the information submitted for review, the request for transforaminal injection at C8 is non-certified.