

Case Number:	CM13-0059592		
Date Assigned:	12/30/2013	Date of Injury:	04/27/2012
Decision Date:	04/07/2014	UR Denial Date:	11/08/2013
Priority:	Standard	Application Received:	12/02/2013

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 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 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 58 year old male who was injured on 04/12/2012 while he was pushing a cart filled with computers which weighed about 75 pounds up a ramp. He tried to prevent the cart from falling and hit his knee against the ramp and felt pain in his back. He felt pain in his right shoulder area. Prior treatment history has included two cervical injections (05/28/2013 and 06/25/2013) and synvisc injections to the left shoulder. Diagnostic studies reviewed include: 08/14/2013: MRI of the cervical spine revealed a loss of lordosis. At C5-C6, there was decreased disc signal and disc space height. There was a 3 mm lateralizing bulge or protrusion with moderately severe neural foraminal encroachment. There was mild to moderate central canal stenosis. At C6-C7, there was decreased disc signal and disc space height. There was a 3 mm broad, rightward bulge with moderate right neural foraminal stenosis. There was mild left neural foraminal stenosis and mild central canal stenosis. At C3-C4, there was a 1-2 mm left greater than right lateralizing bulge with mild left neural foraminal stenosis. The central canal was slightly reduced. 11/14/2013: Nerve conduction studies revealed entrapment neuropathy of the median nerve at the left and right wrist (Carpal Tunnel Syndrome). Mild entrapment neuropathy was noted at the ulnar nerve at the right wrist mainly affecting sensory fiber (Guyon Canal Syndrome). There was very mild entrapment neuropathy of the ulnar nerve at the left wrist mainly affecting sensory fibers (Guyon Canal Syndrome). Interim Ortho Evaluation dated 06/17/2013 reported the patient was s/p cervical ESI that helped him 70%. Physical Examination was two sentences that stated there was tenderness in the left trap and full ROM of the neck and shoulder. Interim Ortho Evaluation dated 07/15/2013 reported the patient had a 2nd ESI which he claimed helped 80%. He had decreased tingling in the fingers, numbness of the hand was still present. Examination showed a positive Phalens test on the right and tenderness in the cervical area and in the left trapezius area. No other PE findings given. PR

09/12/2013 documented the patient to have complaints of constant, severe to moderate radiating neck pain; He had constant, severe pain and stiffness in the shoulder with slight improvement on the right and ongoing on the left. He had numbness in the forearms, wrists and fingers with severe to moderate pain and soreness. His knees exhibited constant, severe to moderate pain and stiffness. He has constant burning in his feet, in the soles. Objective cervical spine findings on exam included moderate to severe palpable tenderness with decreased range of motion; flexion 20/45; extension 25/55; bilateral lateral flexion 20/45; Rotation 45/90 bilaterally; + CCT, +CDT, +FCT, +shoulder dist 11/05/2013 QME documented the patient to have neck pain that was intermittent, usually in the morning or sometimes when using his arms. Pain was rated at a 7-8/10. Cervical spine examination revealed tenderness over the left paraspinal muscle area. No muscle spasms. Compression test was questionably positive with tingling noted in the right hand. Distraction and Spurling test were negative. Range of motion was decreased with extension at 10 (60 normal), Flexion 30 (50 normal), LLB 30 (45 normal), RLB 15 (45 normal), LR and RR normal.

IMR ISSUES, DECISIONS AND RATIONALES

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

3rd cervical epidural steroid injection to C5-C6 and C6-C7: 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: Per the CA MTUS, ESI's are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. The patient has already received 2 cervical ESI's which is within the guidelines. The request for the 3rd injection is outside the guidelines recommendations. Further, the records provided do not show documentation of baselines for improvement from the first or second ESI. The only documentation is that the patient reported 70% and 80% improvement but there was no other information on the physical examination to compare this with. The guidelines state that repeat blocks should be based on continued objective documented pain and functional improvement. Based on the guidelines, the request is non-certified.