

<b>Case Number:</b>	CM14-0000345		
<b>Date Assigned:</b>	01/10/2014	<b>Date of Injury:</b>	08/01/2012
<b>Decision Date:</b>	06/25/2014	<b>UR Denial Date:</b>	12/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/02/2014

### 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 & Rehabilitation, 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 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 injured worker is a 45-year-old male who reported an injury on 08/01/2012. The mechanism of injury was not provided for review. The injured worker underwent an MRI of the cervical spine on 11/21/2013. There was trace neural foraminal narrowing at the right C5-6 and left C6-7 noted but no significant nerve root pathology was identified. The injured worker's treatment history included physical therapy, medications, and activity modifications. The injured worker was evaluated on 12/16/2013. Physical examination of the cervical spine revealed tenderness to the spinous process at the C5-6 with a negative Spurling's sign and equal and bilateral reflexes of the bilateral upper extremities. The injured worker's diagnoses included low back pain syndrome, thoracic lumbosacral radiculitis, and cervicgia. The injured worker's treatment plan included an epidural steroid injection at the C6-7 and massage therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **C6-C7 EPIDURAL STEROID INJECTION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES., CHAPTER: CRITERIA FOR THE USE OF EPIDURAL STEROID INJECTIONS., 46

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

**Decision rationale:** The requested C6-C7 EPIDURAL STEROID INJECTION is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends epidural steroid injections for injured workers who have evidence of radiculopathy upon physical examination that is corroborated by an imaging study and have failed to respond to conservative treatments. The clinical documentation submitted for review does not provide any evidence of radiculopathy upon physical examination. Additionally, the imaging study provided does not support that there is any nerve root compromise. Therefore, an epidural steroid injection would not be appropriate for this patient. As such, the requested C6-C7 EPIDURAL STEROID INJECTION is not medically necessary or appropriate.

**MASSAGE THERAPY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES., CHAPTER: MASSAGE THERAPY, 60

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Massage Therapy Page(s): 60.

**Decision rationale:** The requested MASSAGE THERAPY is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends massage therapy as an adjunct therapy for up to 4 to 6 treatments in the management of chronic pain symptoms. However, the request as it is submitted does not clearly define a duration of treatment or body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested MASSAGE THERAPY is not medically necessary or appropriate.