

Case Number:	CM14-0009219		
Date Assigned:	02/14/2014	Date of Injury:	10/09/2010
Decision Date:	07/25/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	01/23/2014

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 Occupational Medicine 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 56-year-old male who has submitted a claim for chronic neck pain with cervical fusion C3-C6, cervical radiculopathy, lumbar degenerative disc disease and spinal stenosis, lumbar radiculopathy, right hand pain s/p multiple tendon repair, left shoulder pain, and opioid induced constipation associated with an industrial injury date of October 9, 2010. The medical records from 2013-2014 were reviewed. The patient complained of neck and low back pain. The neck pain was rated 7/10 while low back pain was 8/10. The low back pain radiates to the lower extremities. The physical examination showed limited cervical spine range of motion due to pain. The left upper extremity strength gives way secondary to left shoulder pain. The upper extremity deep tendon reflexes are depressed. There was mild tenderness to the lumbar paraspinal muscles bilaterally. The lumbar spine range of motion was decreased as well. An MRI of the cervical spine, dated August 9, 2012, revealed severe foraminal stenosis at C3-C4 and moderate to severe canal stenosis at C4-C5 and C5-C6. Lumbar spine MRI, dated August 9, 2012, showed severe canal stenosis at L4-L5 and L5-S1 secondary to epidural lipomatosis. Official reports of the imaging studies were not available. The treatment to date has included medications, physical therapy, acupuncture, left shoulder surgery, multi-level cervical spine fusion, lumbar epidural steroid injections, right hand tendon repair, cognitive behavior therapy, and activity modification. A utilization review, dated January 17, 2014, denied the request for cervical epidural steroid injection because an MRI of the cervical spine showed no evidence of nerve impingement and there was no documentation of motor weakness, muscle atrophy, dermatomal sensory deficit, and abnormal deep tendon reflexes of the upper extremities in the current progress report. The request for repeat epidural steroid injection L5 was also denied for the same reason as above and because records did not indicate the degree or duration of analgesia from the prior epidural steroid injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

REPEAT LUMBAR EPIDURAL STEROID INJECTION AT L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

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

Decision rationale: According to page 46 of the California MTUS Chronic Pain Medical Treatment Guidelines, criteria for epidural steroid injections include the following: radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing; initially unresponsive to conservative treatment; and no more than two nerve root levels should be injected using transforaminal blocks. Guidelines do not support epidural injections in the absence of objective radiculopathy. In addition, repeat epidural steroid injection should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. In this case, the patient has persistent low back pain with radiation to the lower extremities. Previous epidural steroid injections of the lumbar spine were done which benefited him in the past. The most recent lumbar epidural injection, dated October 21, 2013, provided 50% reduction in pain. However, there was failure to exhibit any evidence of improved performance of activities of daily living and there was no associated reduction of medication intake from the treatment. Although MRI of the lumbar spine dated August 9, 2012 revealed severe canal stenosis at L5-S1, recent progress report dated January 13, 2014 did not show objective evidence of radiculopathy. Furthermore, there is no evidence that patient was unresponsive to conservative treatment. The guideline criteria have not been met. Laterality intended for injection is likewise not specified. Therefore, the request for repeat lumbar epidural steroid injection at L5-S1 is not medically necessary.

CERVICAL EPIDURAL STEROID INJECTION AT C7-T1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

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

Decision rationale: According to page 46 of the California MTUS Chronic Pain Medical Treatment Guidelines, criteria for epidural steroid injections include the following: radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing; initially unresponsive to conservative treatment; and no more than two nerve root levels should be injected using transforaminal blocks. Guidelines do not support

epidural injections in the absence of objective radiculopathy. In addition, repeat epidural steroid injection should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. In this case, the patient has persistent neck pain. Pertinent objective findings include weakness on left upper extremity due to left shoulder pain and depressed upper extremity deep tendon reflexes. There is evidence of cervical radiculopathy. An MRI of the cervical spine dated August 8, 2012 revealed severe foraminal stenosis at C3-C4 and moderate to severe canal stenosis at C4-C5 and C5-C6. However, MRI findings with regards to the C7-T1 level are lacking. Furthermore, there is no evidence that patient was unresponsive to conservative treatment. Recent progress report, dated January 13, 2014, stated the there was better pain control with MS Contin and the medications allow him to do daily functions. The guideline criteria have not been met. Laterality intended for injection is likewise not specified. Therefore, the request for cervical epidural steroid injection at C7-T1 is not medically necessary.