

Case Number:	CM14-0012910		
Date Assigned:	02/24/2014	Date of Injury:	04/27/2011
Decision Date:	06/26/2014	UR Denial Date:	01/14/2014
Priority:	Standard	Application Received:	01/31/2014

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 Pain Medicine and is licensed to practice in Texas and Ohio. 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 53-year-old female who reported an injury on 04/27/2011. The mechanism of injury was not stated. Current diagnoses include lumbar central disc protrusion, multilevel thoracic degenerative disc disease, cervical disc protrusion, right-sided cervical radiculitis, right shoulder partial rotator cuff tear with degeneration, right-sided L5-S1 lumbar radiculopathy, depression, bilateral shoulder rotator cuff syndrome, and left shoulder tendinopathy with degenerative changes. The injured worker was evaluated on 01/30/2014. The injured worker reported severe neck pain with radiation into bilateral upper extremities. The injured worker also reported low back pain and shoulder pain. Physical examination revealed paravertebral muscle spasm and localized tenderness in the lower cervical and right supraclavicular region, restricted cervical range of motion, diminished sensation to light touch in the right upper extremity, restricted range of motion of the lumbar spine, and 4/5 strength in the upper extremities. Treatment recommendations included a translaminar cervical epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE TIME TRANSLAMINAR CERVICAL EPIDURAL STEROID INJECTION (NON SPECIFIED LEVELS): 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 Chronic Pain Medical Treatment Guidelines Page(s): 46.

Decision rationale: California MTUS Guidelines state epidural steroid injections are recommended as an option for treatment of radicular pain, with use in conjunction with other rehab efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. As per the documentation submitted, the injured worker has previously received a translaminar epidural steroid injection that provided 70- 75% pain relief. However, California MTUS Guidelines state repeat blocks are based on objective documented pain and functional improvement, including at least 50% pain relief with an associated reduction of medication use for 6 to 8 weeks following the initial injection. There was no documentation of objective functional improvement with an associated reduction of medication use. Therefore, an additional injection cannot be determined as medically appropriate. There is also no specific level at which the epidural steroid injection will be administered listed in the request. As such, the request is not medically appropriate. Therefore, the request is not medically necessary and appropriate.