

Case Number:	CM14-0167664		
Date Assigned:	10/14/2014	Date of Injury:	02/20/2011
Decision Date:	11/18/2014	UR Denial Date:	09/06/2014
Priority:	Standard	Application Received:	10/10/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Florida. 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 63 year old female who was injured on 2/20/2011. The diagnoses are cervical radiculopathy, lumbar radiculopathy, left shoulder pain and lumbar facet syndrome. There is subjective complaint of neck pain radiating to the upper extremities with associated numbness along the C6 distribution. There was also subjective complaint of low back pain radiating to the lower extremities. The objective findings were positive axial compression test, positive Spurling's test, positive straight leg raising test and decreased sensation along the upper and lower extremities dermatomes. The MRI of the cervical spine showed C5-C6 disc bulge. The MRI of the lumbar spine showed compression fracture L1 and L3, L3-L4 disc bulge with contact to L3 nerve root. The 2013 EMG /NCV showed carpal tunnel syndrome but no cervical radiculopathy. There was no evidence of radiculopathy in the lower extremities. The most recent notes was a hand written note by [REDACTED] dated 9/24/2014. The details were not legible. The pain score was 6-8/10. The medications listed are Anaprox for pain and Sonata for sleep. A Utilization Review determination was rendered on 9/6/2014 recommending non certification for left C5-C6 transfacet epidural steroid injection and left L3-L4 selective epidural catheterization.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Left C5-C6 transfacet epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections, Criteria for the use of Epidural ster.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Neck and Upper Back

Decision rationale: The CA MTUS and ODG guidelines recommend that cervical epidural steroid injection can be utilized for the treatment of cervical radiculopathy when conservative treatment with medications and PT have failed. The records did not show that the patient have established diagnosis of cervical radiculopathy. There were no neurological deficits, radiological finding or EMG/NCS reports to support a diagnosis of radiculopathy. The records did not show that the patient have failed medications management or intensive physical therapy. The criteria for left C5-C6 transfacet epidural injection was not met.

1 Left L3-L4 selective epidural catheterization: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections; Criteria for the use of Epidural ster.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines . Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Low Back

Decision rationale: The CA MTUS and ODG guidelines recommend that lumbar epidural steroid injection can be utilized for the treatment of lumbar radiculopathy when conservative treatment with medications and PT have failed. The records did not show that the patient have established diagnosis of lumbar radiculopathy. There were no neurological deficits, radiological finding or EMG/NCS reports to support a diagnosis of lumbar radiculopathy. The records did not show that the patient have failed medications management or intensive physical therapy. The criteria for left L3-L4 selective epidural catheter injection was not met.