

Case Number:	CM14-0171524		
Date Assigned:	10/23/2014	Date of Injury:	09/09/2010
Decision Date:	11/21/2014	UR Denial Date:	09/11/2014
Priority:	Standard	Application Received:	10/16/2014

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 Family Practice and is licensed to practice in 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 58-year-old male with a date of injury of September 9, 2010. He complains of right shoulder pain, neck pain radiating into the upper extremities, mid back pain, and low back pain radiating into the lower extremities. An MRI scan of the thoracic spine revealed disc bulging, facet arthropathy and effacement of the thecal sac at T8-T9, T9-T10, and T10-T11 although the actual report was not included for review. An MRI scan of the cervical spine revealed disc bulging, facet arthropathy, effacement of the thecal sac and severe foraminal narrowing bilaterally at C3-C4, on the right side at C4-C5, and evidence of a fusion surgery at C5-C6 and C6-C7 although the actual report was not included review. Previous surgeries include 3 surgeries to repair the right shoulder rotator cuff, a cervical fusion, and a lumbar fusion in 2012. The physical exam reveals diminished cervical range of motion with a positive Spurling's test bilaterally. No neurologic deficits were detected in the upper extremities. The thoracic spine reveals diminished range of motion with tenderness to palpation of the paraspinal musculature and facet joints with pain radiating to the anterior chest with extension of the thoracic spine. The injured worker has been treated with oral opioids, anticonvulsant drugs, and epidural steroid injections previously. The provided diagnoses include failed back syndrome, complete rotator cuff repair, status post rotator cuff repair, and chronic pain syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical ESI C7-T1 and Thoracic ESI T7-T8 translaminar: Upheld

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

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

Decision rationale: According to guidelines, epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, and muscle relaxants). Injections should be performed using fluoroscopy (live x-ray) for guidance. If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. No more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level should be injected at one session. In the therapeutic phase, repeat blocks 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. Current research does not support a "series-of-three" in either the diagnostic or therapeutic phase. Guidelines recommend no more than 2 ESI injections. In this instance, the physical examinations provided for review do not provide corroborative evidence of radiculopathy in the cervical or thoracic regions. The injured worker did have a positive Spurling's test, but there is no correlation provided with symptoms at a dermatomal level. The upper extremity neurologic examination was documented as normal. Additionally, there is documentation of tenderness of the thoracic facet joints with radiation of pain anteriorly, but again there was no dermatomal corroboration, such as chest wall numbness. Therefore, epidural steroid injections at the C7-T1 and T7-T8 levels are not medically necessary per the referenced guidelines after a review of provided records.