

Case Number:	CM14-0021815		
Date Assigned:	02/24/2014	Date of Injury:	09/02/2004
Decision Date:	06/27/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	02/21/2014

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 Emergency 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:

Patient with reported date of injury of 9/2/2004. No mechanism of injury was provided. Patient has diagnoses of Cervical disc herniation with radicular symptoms, post R total knee arthroplasty, R shoulder impingement syndrome, carpal tunnel syndrome of R wrist status post tunnel release, lumbar disc lesion with radiculitis, anxiety with depression, insomnia and L knee pain. Medical records from primary treating physician and consultants reviewed. Several non-relevant imaging reports of shoulder were not reviewed. Many of the reports seem to deal with complains of shoulder pains. Last report provided dated 1/31/14 was a reply to a prior UR rejection. Patient has complains of neck pain radiation to R shoulder. Objective exam shows tenderness over cervical paraspinal muscles R greater than L. Mobility restricted by pain. Tenderness to palpation along cervical musculature with spasms. Positive Spurling's test. Hypoaesthesia on C4-5 and C5-6 dermatome. The treating physician's report states that the epidural steroid injection is for analgesia and therapeutic purposes. There no mention of long term plan along with physical therapy or any other treatment modality after ESI is done. MRI of Cervical Spine(11/4/13) reveals C4-5 with 2mm disc protrusion with endplate and uncinat spur formation. Mild impression of anterior aspect of spinal cord without any stenosis. C5-6 with 3mm R paracentral posterior disc protrusion that impress on anterior aspect of spinal cord. Mild spinal canal stenosis. No foraminal stenosis. C6-7 with 2mm posterior disc protrusion with endplate and uncinat spur formation. No stenosis. There is mention that patient is on medication but no medication list or patient's underlying medical history was provided. There is no documentation of prior attempted conservative treatment provided. Utilization review is for cervical epidural steroid injections(CESI) at C4-5 and C5-6 under fluoroscopy and pre-operative laboratory testing(CBC, SMA-7, PT/INR, PTT). Prior UR on 2/13/14 recommended non-certification. As per note, this review was the 2nd request.  

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL EPIDURAL STEROID INJECTIONS (CESI) AT C4-C5, C5-C6 UNDER FLUOROSCOPY: 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, EPIDURAL STEROID INJECTIONS (ESI) ,

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

Decision rationale: As per MTUS Chronic Pain Guidelines, Epidural Steroid Injections(ESI) may be recommended but has little utility except for short term pain relief. Its primary utility is temporary pain relief to facilitate more active treatment programs to avoid surgery. Patient does not meet criteria for ESI. There is no documentation of failed conservative treatment despite vague mention of these interventions by the treating physician. There is no documentation of physical therapy, exercise regiment or medication therapy attempted on the provided records. The primary treating physician's lack of documentation of long term goal and plan of ESI also does not support the use of ESI. ESI without home exercise program and physical therapy will not not provide any long term improvement in function or pain. There is no documentation that there is a plan of physical therapy or other more active treatment programs after ESI is done. ESI is not medically necessary.  

PRE OPERATIVE LABORATORY TESTS (CBC, SMA-7, PT, PTT, INR): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Low back-Lumbar and Thoracic(Chronic and acute)>, <Preoperative lab testing

Decision rationale: c) My rationale for why the requested treatment/service is or is not medically necessary: There are no appropriate sections in the MTUS Chronic pain or ACOEM guidelines concerning this topic. As per Official Disability Guide, lab testing may be considered under specific conditions. There is no documentation of any risks or illness that indicate the need for preoperative testing. The requested procedure is also not certified as medically necessary therefore the request for preoperative lab testing is also not medically necessary.