

Case Number:	CM14-0045217		
Date Assigned:	06/20/2014	Date of Injury:	08/22/2005
Decision Date:	07/17/2014	UR Denial Date:	03/01/2014
Priority:	Standard	Application Received:	03/12/2014

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 and Rehabilitation, and is licensed to practice in New York and Texas. 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 47-year-old male who reported an injury on 08/22/2005. The mechanism of injury was not provided. The clinical note dated 01/21/2014 noted the injured worker presented with neck and low back pain. Upon examination, the cervical range of motion values was limited to about 50% of flexion and extension. Left and right rotation are about 75% of normal. There is tenderness to paraspinal and C3-4 area of the spine and over the lower cervical spine from C5 through T1. Prior treatment included home exercise, chiropractic treatment, activity modification, and medications. The diagnoses were multilevel cervical degenerative disc disease, multilevel cervical spondylosis with facet arthrosis, C5-6, C6-7, and C7-T1, anterior interbody fusion, L4-5, left sacroiliac joint arthrodesis, and lumbar pain. The provider recommended a translaminar epidural T1-T2 via catheter up to C5 and 1 office visit. The request for authorization was dated 02/21/2014. The provider's rationale was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE (1) TRANSLAMINAR EPIDURAL T1-2 VIA CATHETER UP TO C5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTION Page(s): 46.

Decision rationale: The MTUS Guidelines state an epidural steroid injection may be recommended to facilitate progress and more active treatment programs when there is radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Additionally, documentation should show that the injured worker was initially unresponsive to conservative treatment. The documentation submitted for review stated that the injured worker completed initially recommended conservative treatment, but continued to complain of tenderness directly in the midline at the C3-4 area and paraspinal tenderness over the lower cervical spine from C5 through T1. No sensory deficits were noted. No motor strength deficits were noted. Physical exam and diagnostic testing do not clearly corroborate radiculopathy. There is lack of positive provocative testing indicating radiculopathy in the physical examination. Note that injections should be performed using fluoroscopy for guidance and no more than 2 nerve root levels should be injected using transforaminal blocks. The provider's request indicates an epidural steroid injection from the T1 to C5, which exceeds the guideline recommendations. Furthermore, the provider's request does not indicate the use of fluoroscopy for guidance. As such, the request is not certified.

ONE (1) OFFICE VISIT - FOLLOW UP: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177. Decision based on Non-MTUS Citation Official Disability GUIDELINES, Neck and Upper Back (Acute &Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Office Visit.

Decision rationale: The request for an office visit is non-certified. The Official Disability Guidelines (ODG) recommends office visits for proper diagnosis and return to function of an injured worker. The need for a clinical office visit with a health care provider is individualized based upon a review of the injured worker's concerns, signs and symptoms, clinical findings, and reasonable physician judgment. As injured workers' conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best injured worker outcomes are achieved with eventual independence from the health care system through self care as soon as clinically feasible. The provider stated that the office follow up was to discuss results of the requested MRI (magnetic resonance imaging); however, the MRI of the cervical spine has not been approved. As such, the request is non-certified.