Case Number:	CM14-0052919		
Date Assigned:	07/07/2014	**Date of Injury:**	06/12/2013
Decision Date:	08/21/2014	**UR Denial Date:**	03/24/2014
Priority:	Standard	**Application Received:**	04/21/2014

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 Family Medicine and is licensed to practice in North Carolina. 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 50 year-old with a reported date of injury on 06/12/2013 that occurred when the patient slipped and fell at work. The patient has the diagnoses of right knee contusion, left knee contusion, right wrist strain, left wrist strain, lumbosacral strain and cervical strain. Treatment modalities have included medication, physical therapy and acupuncture. Per the requesting physician's progress notes dated 01/07/2014, the patient has complaints of constant, sharp pain in the above-mentioned joints with numbness in both hands and weakness in the arms. The pain is rated a 8/10. Physical exam noted limited range of motion in the cervical spine with tenderness over the cervical spinous processes and interspaces from C3-C7. There was limited range of motion in the lumbar spine and tenderness over the lumbar spinous processes and interspaces from L3-S1 and tenderness over the facet joints form L3-S1 bilaterally, with bilateral positive straight leg raise and diminished sensation in the L4-S1 nerve root distribution. Treatment plan consisted of topical analgesics, request for cervical epidural injection at C6-7 to decrease neck and upper extremity pain, L4-5 lumbar epidural steroid injections X1 and bilateral L5-S1 transforaminal epidural injections to decrease lower back and lower radicular pain and continuation of home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Epidural Steroid Injection and 62275 x 1 at C6-C7: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epdiural injections Page(s): 46.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines section on epidural injections states:It is recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below.The most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a series of three ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-termPain relief beyond 3 months and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. Per these guidelines there is not enough evidence in the literature to support the recommendation for the use of epidural steroid injections to treat cervical pain. For this reason, Cervical Epidural Steroid Injection and 62275 x 1 at C6-C7 is not medically necessary.