

Case Number:	CM14-0060621		
Date Assigned:	07/09/2014	Date of Injury:	11/14/1980
Decision Date:	09/08/2014	UR Denial Date:	04/16/2014
Priority:	Standard	Application Received:	05/01/2014

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 Management and is licensed to practice in Tennessee. 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:

This is a 56 year old male with a date of injury 11/14/80. The exact mechanism of injury was not clearly described. A progress note from 3/20/14 reported subjective findings of neck pain described as dull, achy, and stabbing with associated radiation into the right shoulder. The patient also complained of headaches and paresthesias in his hand along with weakness and numbness of the arm. Objectively the patient was noted to have asymmetry of the neck and shoulders with tilting of the head and neck to the left. There was tenderness to palpation over the trapezius with muscle spasm. Cervical spine range of motion was limited. Right biceps DTR was 1+. Upper extremity sensation to light touch was diminished in the C5 and C6 dermatome. Strength was 5/5 in the upper extremity. The patient had undergone a prior cervical ESI on 2/21/14 which was noted to have yielded 50% pain relief. An MRI of the cervical spine dated 9/19/2013 noted C5-C6 3mm disc protrusion with bilateral nerve root compromise and 3mm disc protrusion anteriorly as well. Diagnostic Impression: Cervical Radiculitis. Treatment to date: Medication Management, prior cervical ESI, and Physical Therapy. A UR decision dated 4/15/14 denied the request for 1 second C5-C6 Cervical Steroid Injection with epidurography. Four weeks after her first cervical ESI, patient reported that her pain was returning. In the therapeutic phase, repeat blocks should only be performed if there is persistent pain relief as well as associated reduction of medication usage for six to eight weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Second C5-C6 Cervical Epidural Steroid Injection under monitored anesthesia with epidurography (Priority care solutions) to be conducted at [REDACTED]: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural Steroid Injections. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: AMA Guides (Radiculopathy).

Decision rationale: CA MTUS supports Epidural Steroid Injections in patients with radicular pain that has been unresponsive to initial conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In addition, no more than two nerve root levels should be injected using transforaminal blocks and no more than one interlaminar level should be injected at one session. Furthermore, CA MTUS states that repeat blocks should only be offered if at least 50% pain relief with associated reduction of medication use for six to eight weeks was observed following previous injection. However, although radiculopathy was apparent on physical examination with corroborating MRI findings, at least 50% pain relief from the first cervical ESI was not maintained at six to eight weeks. At four weeks post-procedure the patient's pain worsened after an initial pain reduction of 50%. Additionally, there is not clear documentation of reduction of the use of medication. Therefore, the decision for 1 Second C5-C6 Cervical Steroid Injection under monitored anesthesia with epidurography is not medically necessary.