

Case Number:	CM14-0097817		
Date Assigned:	07/25/2014	Date of Injury:	04/28/2010
Decision Date:	08/28/2014	UR Denial Date:	05/21/2014
Priority:	Standard	Application Received:	06/18/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 46-year-old female who reported an injury on 04/28/2010. The mechanism of injury was not stated. The current diagnosis is displacement of lumbar intervertebral disc without myelopathy. The injured worker was evaluated on 04/15/2014 with complaints of persistent pain in the upper and lower back with numbness and tingling in the left lower extremity. It is noted that the injured worker is status post lumbar radiofrequency ablation without lasting benefit. Previous conservative treatment also includes physical therapy, acupuncture, transforaminal epidural steroid injections and TENS therapy. Physical examination of the cervical spine revealed full range of motion, tenderness to palpation over the bilateral cervical paraspinal muscles, normal bulk and tone in all major muscle groups of the upper and lower extremities, diminished strength in the left upper extremity and decreased sensation in the C6 and C7 dermatomes of the upper extremity. Treatment recommendations included a cervical epidural steroid injection at C6-7.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Steroid Injection C5-7: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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

Decision rationale: The California MTUS Guidelines state that epidural steroid injections are recommended as an option for treatment of radicular pain with use in conjunction with active rehab efforts. There was no documentation of an attempt at conservative treatment for the cervical spine. There were also no imaging studies or electrodiagnostic reports submitted for review to corroborate a diagnosis of cervical radiculopathy. Based on the clinical information received, the request is not medically necessary.