

Case Number:	CM14-0180497		
Date Assigned:	11/05/2014	Date of Injury:	10/15/2005
Decision Date:	01/28/2015	UR Denial Date:	10/13/2014
Priority:	Standard	Application Received:	10/30/2014

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 Medicine and is licensed to practice in Georgia. 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 female presenting with a work-related injury continuous from 2000 to 2005. The patient complained of neck pain and left upper extremity pain. According to the medical records the patient has tried multiple modalities and eventually underwent cervical discectomy anteriorly at C4 - C5 and C5 - C6. The physical exam is significant for cervical spine tenderness from T-3 C6 level bilaterally, bilateral cervical facet tenderness at C6 - C7; pain in the cervical spine worsens on extension, side bending and rotation of the spine; range of motion of the cervical spine from severely limited; deep tendon reflexes are one class on the left and to five on the right at the triceps and brachioradialis muscles; weakness in the left upper extremity and C5 - C6 myotomes; lumbar spine is mildly tender in the L4 - L5 level; pain in the lumbar spine worsens on extension of the spine, and range of motion of the lumbar spine is limited. The medical records further states that the neurological exam was normal. The patient was diagnosed with left cervical radiculopathy with neural claudication, post cervical discectomy and anterior fusion C4 - C5 and C5 - C6 level, probable cervical epidural scarring/fibrosis, failed conservative therapies for pain control, status post lumbar discectomy L4 - L5, L5 - S1 level, and insomnia and anxiety secondary to chronic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Transforaminal Cervical Epidural Injection C5-6, C6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 47.

Decision rationale: Left Transforaminal Cervical Epidural Injection C5-6, C6-C7 levels under fluoroscopy x 1 anesthesia. The California MTUS page 47 states "the purpose of epidural steroid injections is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone is no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment, injections should be performed using fluoroscopy; if the ESI is for diagnostic purposes a maximum of 2 injections should be performed. No more than 2 nerve root levels should be injected using transforaminal blocks. No more than 1 interlaminar level should be injected at one session. In the therapeutic phase repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6-8 weeks, with the general recommendation of no more than 4 blocks per region per year. Current research does not support a series of 3 injections in either the diagnostic or therapeutic phase. We recommend no more than 2 epidural steroid injections." The ODG states that in terms of sedation with epidural steroid injections, the use of IV sedation (including other agents such as Modafinil) may interfere with the result of the diagnostic block, and should only be given in cases of extreme anxiety. Additionally, a major concern is that sedation may result in the inability of the patient to experience the expected pain and parathesias associated with spinal cord irritation. The claimant's physical exam and MRI is consistent with radiculopathy in the distribution of the epidural treatment level; however, anesthesia is not recommended with epidural steroid injection as it takes away the patients protective defenses and there is lack of documentation of extreme anxiety. The requested procedure is not medically necessary per ODG and CA MTUS guidelines.