

Case Number:	CM14-0196260		
Date Assigned:	12/04/2014	Date of Injury:	11/13/2012
Decision Date:	01/21/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/24/2014

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 Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 an injured worker with a history of cervical and lumbar spine conditions. Date of injury was 11-13-2012. Agreed medical evaluation dated October 7, 2013 documented MRI magnetic resonance imaging of the cervical and lumbar spine. MRI magnetic resonance imaging of the cervical spine dated April 10, 2013 demonstrated degenerative disc disease at C5-C6 and bilateral uncovertebral joint spurring at C5-C6 producing moderate narrowing of the C6 neural foramina on both sides. This was associated with a 1-2 mm circumferential disc bulge. Superior endplate irregularity of C6 and inferior endplate irregularity of C5 is noted. The MRI report does not suggest a C4-C5 anterolisthesis. MRI magnetic resonance imaging of the lumbar spine dated April 10, 2013 noted desiccation of the discs at L2-L3, L3-L4, L4-L5, and L5-S1. There is a 3 mm left L2-L3 foraminal disc protrusion compromising the left L2 neural foramen. The disc bulge is 3 mm. The left L2 nerve root is superiorly displaced. Chief complaints were cervical spine pain and lumbar spine pain. History of present illness was documented. On November 13, 2012, the patient engaged in forceful wrestling. Over those three days, she developed severe pain in her neck and back. The patient completed a course of physical therapy in 2013. The patient reports pain in her cervical spine. She has constant pain in the lumbar spine. She denies radiation of symptoms to her legs or numbness and tingling in the lower extremities. She notes that physical therapy improved her cervical spine and lumbar spine pain by about 50%. She continues to do a home exercise program. She reports her shoulders are fine. The injury is really to the neck and back but she did have radiation of pain to the shoulders. She does not have a separately identifiable injury, in her opinion, to her shoulders. She reports pain in her cervical spine and lumbar spine that is mechanical in nature. She notes she has pain with movements and activities. She denies radiation of pain or numbness and tingling into the hands or lower extremities. She

reports pain in the lumbar spine on range of motion testing. The pain in the back on examination is mostly over the soft tissues. Light to moderate touch of the lumbar spine causes her to withdraw and reproduces her pain. When she stands her shoulders and pelvis are level. Her spine is straight. There is no apparent scoliosis. The pelvis is stable to distractive and compressive forces. Sensation is grossly intact to light touch in the C5 through T1 dermatomes and the L3 through S1 dermatomes. Provocative testing for carpal and cubital tunnel syndrome is entirely negative. Intrinsic muscle strength in the hands is 5/5. There is no visible or palpable evidence of atrophy. Diagnoses were degenerative disc disease and degenerative joint disease in the cervical spine with mechanical cervical spine pain, and degenerative disc disease and degenerative joint disease in the lumbar spine with mechanical lumbar spine pain. Epidural steroid injections of bilateral C6-7 and left L2-3 were requested on 10-20-2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral C6-7 cervical epidural steroid injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175, 181-183, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses epidural steroid injection (ESI). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints states that cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. Medical treatment utilization schedule (MTUS) Chronic Pain Medical Treatment Guidelines (Page 46) states that epidural steroid injections (ESI) are an option for radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The American Academy of Neurology recently concluded that there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. ESI treatment alone offers no significant long-term functional benefit. Criteria for the use of epidural steroid injections requires that radiculopathy must be documented by physical examination and corroborated by imaging studies or electrodiagnostic testing. The agreed medical evaluation (AME) report dated October 7, 2013 documented that the patient denied radiation of pain or numbness and tingling into the hands or lower extremities. The 10/7/13 AME report was the latest progress report in the submitted medical records. No medical records from the year 2014 were present in the submitted medical records. The Detailed Reevaluation report dated 10/9/14 was regarding a different patient, with a different name, date of injury, and employer. Epidural steroid injections of bilateral C6-7 and left L2-3 were requested on 10-20-2014. Without recent progress reports, the request for epidural steroid injections is not supported. Therefore, the request for Bilateral C6-7 cervical epidural steroid injection is not medically necessary.

Left L2-3 lumbar epidural steroid injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses epidural steroid injections (ESIs). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 300) states that invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Epidural steroid injections treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Chronic Pain Medical Treatment Guidelines (Page 46) states that epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The American Academy of Neurology concluded that epidural steroid injections do not affect impairment of function or the need for surgery and do not provide long-term pain relief. ESI treatment alone offers no significant long-term functional benefit. Criteria for the use of epidural steroid injections requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The agreed medical evaluation (AME) report dated October 7, 2013 documented that the patient denied radiation of pain or numbness and tingling into the hands or lower extremities. The 10/7/13 AME report was the latest progress report in the submitted medical records. No medical records from the year 2014 were present in the submitted medical records. The Detailed Reevaluation report dated 10/9/14 was regarding a different patient, with a different name, date of injury, and employer. Epidural steroid injections of bilateral C6-7 and left L2-3 were requested on 10-20-2014. Without recent progress reports, the request for epidural steroid injections is not supported. Therefore, the request for Left L2-3 lumbar epidural steroid injection is not medically necessary.