

Case Number:	CM14-0203882		
Date Assigned:	12/16/2014	Date of Injury:	01/20/2010
Decision Date:	02/05/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/05/2014

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 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 48 year old male who sustained a repetitive work related injury to his bilateral forearms, wrists and cervical spine on January 20, 2010. No mechanism of injury or occupation was noted in this review. The patient underwent an anterior cervical fusion C5-6 in April 2013 according to the utilization review document. The injured worker is diagnosed with cervical radiculopathy, degenerative disc disease and cervical post laminectomy syndrome. Magnetic resonance imaging from November 10, 2014 revealed mild posterior disectomy protrusion osteophytic complex at C4-5. The C6-7 and C7-T1 level showed no significant disc protrusion or stenosis. According to the treating physician's progress report from October 17, 2014 the injured worker continues to experience cervical pain with burning, tingling and numbness to the arms and forearms bilaterally. Muscle strength intact with biceps and brachioradialis but was negative 5 on the left with triceps. The current treatment modalities consist of conservative care, physical therapy and medication. The injured worker remains on temporary total disability (TTD). The treating physician has requested authorization for an interlaminar cervical epidural steroid injection for C5-6 and C6-7 levels under epidurography and conscious sedation. On November 25, 2014 the Utilization Review denied certification for the interlaminar cervical epidural steroid injection for C5-6 and C6-7 levels under epidurography and conscious sedation. Citations used in the decision process were the Medical Treatment Utilization Schedule (MTUS) Chronic Pain Guidelines on epidural steroidal injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interlaminar cervical epidural steroid injection for the C5-6 and C6-7 levels under epidurography and conscious sedation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 47. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Extremity Complaints, Treatment Consideration: Epidural Steroid Injections.

Decision rationale: Interlaminar Cervical Epidural Steroid Injection for the C5-6 and C6-7 Levels under Epidurography and Conscious Sedation. 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 symptoms 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. Additionally, the guidelines only recommend one level for interlamina injections. The requested procedure is not medically necessary per ODG and CA MTUS guidelines.