MAXIMUS Federal Services

Case Number:	CM15-0109366		
Date Assigned:	06/16/2015	Date of Injury:	07/31/2013
Decision Date:	08/31/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	06/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Arizona, California
Certification(s)/Specialty: Family Practice

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 (IW) is a 46 year old male who sustained an industrial injury on 07/31/2013. He reported lifting something into a dumpster when he developed shoulder pain. As the shoulder improved, he noted numbness over the ulnar aspects of the hands. The injured worker was diagnosed as having: Bilateral ulnar neuropathy at the elbows, Possible carpal tunnel syndrome on the left, Lateral femoral cutaneous neuropathy causing right thigh numbness, Peripheral neuropathy causing numbness in the feet, Back and neck pain likely relating to degenerative disc disease and possible cervical radiculopathy on the left. Treatment to date has included medication for pain, and a work up that included MRI of the cervical spine. Currently, the injured worker complains of paresthesias and numbness in the ulnar aspects of the hands. In the provider notes of 02-24-2015, the worker also complains of neck pain radiating into his head, causing headaches, and low back pain radiating to the lower extremities at times. In the exam of 03-25-2015, there was noted paraspinal tenderness to palpation with restriction in mostly flexion secondary to pain. He may awaken at night with numbness in the hands. Pain also develops at times in the thenar eminence which can travel up the forearm towards the shoulder on the left side. He complains of constant numbness over the anterolateral thigh on the right and over the lateral aspect of both feet. The pain does not travel, but there have been two occasions where there was numbness in the left leg while sitting, that resolved with position change. There are no complaints of radicular pain.MRI studies of the cervical change were reported to demonstrate degenerative disc changes in the cervical spine with no evidence for spinal cord compression. ON exam, there was no motor weakness, and sensory exam was unremarkable. There are no

clear deficits in the hands. Gait is normal. Reflexes are active and symmetrical throughout. Plantar response is flexor bilaterally. Treatment recommendations were for electromyogram nerve conduction studies of both upper and lower extremities, and labs with a blood sugar to rule out diabetes. A request was made for a Cervical Translaminar ESI C6-7.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Translaminar ESI C6-7: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural injections Page(s): 47.

Decision rationale: According to the guidelines, the criteria for the use of Epidural steroid injections: Note: The purpose of ESI 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 offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) 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 six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In this case, the claimant had a diagnosis of cervical strain. The exam findings and imaging did not correlate to radiculopathy. The request for a cervical ESI is not justified and not medically necessary.