

Case Number:	CM15-0136081		
Date Assigned:	07/24/2015	Date of Injury:	02/19/2015
Decision Date:	08/21/2015	UR Denial Date:	07/06/2015
Priority:	Standard	Application Received:	07/14/2015

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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 57 year old male who sustained a work related injury February 19, 2015. Past surgical history is documented as oncology surgery right knee x 4, left foot x 2, right elbow, and right shoulder. According to the emergency department records, dated February 19, 2015, the injured worker presented for evaluation after being struck in the head by a steel beam, while wearing a hard hat, causing axial load and neck pain primarily on the left side of the neck, without loss of consciousness or any other complaints. Past history included hypertension, hyperlipidemia, and left foot surgery. He was diagnosed with a cervical strain. A cervical spine x-ray was determined to be negative for fracture; noted degenerative disc disease and facet arthropathy, partial ossification anterior longitudinal ligament C5. He was provided ibuprofen and home instruction. According to a detailed orthopedic consultation, dated June 19, 2015, the injured worker presented with ongoing left sided neck pain and occasional numbness down the outer part of his left upper arm to his elbow. He reports completing 14 sessions of physical therapy and ibuprofen which are both helping. He is currently working light duty. Physical examination included; able to toe and heel walk, and perform tandem gait and gait is normal. Examination of the cervical spine revealed tenderness of the trapezius, tenderness of the sternocleidomastoid, trapezius, and the levator scapulae. There is tenderness of the occipital protuberance and the C3 spinous process. Active range of motion recorded as; rotation to the left 10 degrees and lateral flexion to the left 5 degrees with flexion and extension normal. A cervical spine x-ray taken in the office this visit June 19, 2015 revealed cervical lordosis decreased, disc

height loss at C3-4, posterior osteophytes, disc height loss C5-6 (spondylolisthesis C5-6) and disc height loss C6-7 but no fracture, or dislocation. Diagnoses are cervicalgia; cervical spondylosis with radiculopathy. Treatment plan included referral to physical therapy and at issue, a request for authorization for cervical transforaminal epidural injection left C3-4.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical transforaminal epidural steroid injection at left C3-4: Overturned

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 Injections Section Page(s): 46.

Decision rationale: The MTUS Guidelines recommend the use of epidural steroid injections (ESIs) as an option for treatment of radicular pain. Radicular pain is defined as pain in dermatomal distribution with corroborative findings of radiculopathy. Research has shown that less than two injections are usually required for a successful ESI outcome. A second epidural injection may be indicated if partial success is produced with the first injection, and a third ESI is rarely recommended. ESI can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The treatment alone offers no significant long-term functional benefit. Criteria for the use of ESI include radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, and failed conservative treatment. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medications use for six to eight weeks. In this case, the injured worker was diagnosed with a cervical strain. A cervical spine x-ray was determined to be negative for fracture; noted degenerative disc disease and facet arthropathy, partial ossification anterior longitudinal ligament C5. An updated cervical spine x-ray taken in the office on June 19, 2015 and revealed cervical lordosis decreased, disc height loss at C3-4, posterior osteophytes, disc height loss C5-6 (spondylolisthesis C5-6) and disc height loss C6-7 but no fracture, or dislocation. Diagnoses are cervicalgia and cervical spondylosis with radiculopathy. The injured worker's condition and presentation meets the requirements of the guidelines, therefore, the request for cervical transforaminal epidural steroid injection at left C3-4 is determined to be medically necessary.