

Case Number:	CM15-0180019		
Date Assigned:	09/21/2015	Date of Injury:	03/03/2014
Decision Date:	11/02/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/14/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 48 year old female who sustained an industrial injury on 3-3-14. Previous treatment includes physical therapy, medication, surgery, MRI, and CT Myelogram 7-14-15. In a note dated 8-5-15, the physician reports the injured worker is seen for her 5th post-operative visit. On 10-21-14 she had a C4-C5 and C5-C6 anterior cervical discectomy and fusion with plating. It is noted she feels she is getting worse. Her hands are cramping, and she is having "horrible" neck pain, headaches, bilateral arm pain, unusual blurry vision, dizziness and vertigo. The CT Myelogram done 7-14-15 shows the instrumentation appears in good position, she has not fused completely yet, there is no significant stenosis and it is read as a left C3-C4 nerve root under filling but it is noted no significant nerve root compression or spinal stenosis is seen to explain her symptoms. The plan is for an epidural steroid injection of the cervical spine. The requested treatment of cervical epidural steroid injection at C3-C4 was non-certified on 8-28-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Epidural Steroid Injection at C3-4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: Per the MTUS CPMTG epidural steroid injections are used 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 benefit. The criteria for the use of epidural steroid injections are as follows: 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. CT myelogram of the cervical spine dated 7/14/15 showed status post C4-C5 and C5-C6 anterior cervical discectomy and fusion with plating and screws, instruments in a good position, a left C3-C4 nerve root under filing with no significant nerve root compression or spinal stenosis, a minor dorsal osteocartilaginous ridging across C4-C5 and C5-C6 without central stenosis. The documentation submitted for review does not contain physical exam findings of radiculopathy or clinical evidence of radiculopathy. Above-mentioned citation conveys radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Radiculopathy is defined as two of the following: weakness, sensation deficit, or diminished/absent reflexes associated with the relevant dermatome. These findings are not documented, so medical necessity is not affirmed. As the first criteria are not met, the request is not medically necessary.