

Case Number:	CM15-0184263		
Date Assigned:	09/24/2015	Date of Injury:	03/28/2014
Decision Date:	11/06/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/18/2015

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 46 year old male, who sustained an industrial injury on 03-28-2014. He has reported injury to the neck and back. The injured worker is being treated for cervical sprain-strain; thoracic sprain-strain; lumbar sprain-strain; sacroiliac region sprain-strain. Treatment to date has included medications, diagnostics, acupuncture, chiropractic therapy, and physical therapy. A progress report from the treating physician, dated 06-02-2015, documented an evaluation with the injured worker. The injured worker reported neck pain; mid-upper back pain; lower back pain; right shoulder pain; bilateral wrist pain; bilateral knee pain; and right foot pain. Objective findings included pain and myospasm to palpation of the right and left cervical paraspinals, and right and left trapezius; decreased cervical spine ranges of motion; right and left compression tests are positive; right and left shoulder depression tests are positive for neck pain; sensation is decreased at C7 dermatome on the left; there is pain and myospasm to palpation of the right and left thoracic paravertebrals; Kemp's test is positive on the right and left; there is pain and myospasm to palpation of the right and left lumbar paravertebrals, and right and left sacroiliac joint; lumbar ranges of motion are decreased; Kemp's test is positive on the right and left for lumbar spine pain; and Patrick Fabere's test is positive on the left and right for back pain. The treatment plan has included the request for 1 cervical epidural injection. The original utilization review, dated 09-08-2015, non-certified the request for 1 cervical epidural injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 cervical epidural injection: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and 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. Per progress noted dated 7/7/15, the injured worker had left hand weakness which would occasionally cause him to drop things. Per exam dated 6/2/15 sensation was decreased at the left C7 dermatome. Reflexes were within normal limits. MRI of the cervical spine dated 3/23/15 revealed mild disc degeneration and bulges, however the neural foramina were patent and articular facets were normal. The documentation submitted for review does not contain physical exam findings of radiculopathy or clinical evidence of radiculopathy. The MRI findings documented do not demonstrate findings consistent with radiculopathy. Above-mentioned citation conveys radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. As the imaging studies do not corroborate radiculopathy, and the requested level is not specified, the request is not medically necessary.