

Case Number:	CM15-0185987		
Date Assigned:	09/28/2015	Date of Injury:	09/08/2014
Decision Date:	11/10/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	09/21/2015

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 61 year old female who sustained an industrial injury September 15, 2014. A complex neurological evaluation dated January 28, 2015, diagnoses are documented as cervical radiculopathy involving C5, C6 nerve roots bilateral; carpal tunnel syndrome, bilateral right greater than left; lumbosacral radiculopathy involving the L4-5 nerve roots, left greater than right; headaches, probably cervicogenic. According to a primary treating physician's progress report dated July 27, 2015, the injured worker presented for follow-up with complaints of cervical spine and lumbar spine pain. She reports using Motrin is causing dyspepsia. Current medication included Alprazolam, Omeprazole, and ibuprofen. Objective findings included; 5' and 185 pounds; right handed; cervical spine- midline tenderness at C5-6, C6-7, left paravertebral muscle at C6 and in the trapezius and levator scapulae muscles; upper extremity weakness noted in the left wrist extensors, biceps, and forearm supinator muscles; decreased sensation in the left C5 and C6 dermatomes with pinprick and light touch. Assessment is documented as left upper extremity radiculitis; sleep disturbance secondary to chronic pain; cervical myospasm. Previous treatment modalities not specified in this medical record available for review. Treatment plan included discontinuing Motrin and replace with Relafen to try Tylenol #3 and Norflex, and at issue, a request for authorization dated August 26, 2015, for cervical (ESI) epidural steroid injection at C7-T1 with fluoroscopy. According to utilization review dated September 15, 2015, the request for cervical epidural steroid injection C7-T1 with fluoroscopy is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical ESI (epidural steroid injection) at C7-T1 with fluoroscopy: 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 .Per progress report dated 7/27/15, physical exam noted lower cervical tenderness and upper extremity weakness of left wrist extensors, biceps and forearm supinator muscles. Decreased sensation was noted about the left C6 and C5 dermatomes with pinprick and a light touch. Reflexes were noted to be 1+ at the bilateral biceps, triceps and brachioradialis. It was noted that MRI of the cervical spine dated 12/23/14 revealed some compromise of the exiting nerves at the C5-C6 level. Above mentioned citation conveys radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. As MRI study does not corroborate radiculopathy at C7-T1, the request is not medically necessary.