

Case Number:	CM15-0189531		
Date Assigned:	10/01/2015	Date of Injury:	04/29/2008
Decision Date:	11/16/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/25/2015

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 male, who sustained an industrial injury on 4-29-2008. The injured worker was being treated for cervical radiculopathy, cervical stenosis, and degenerative disc disease of the cervical spine. On 8-5-2015, the injured worker reported ongoing aching neck pain radiating into the trapezius musculature. He reported stabbing pain along the left shoulder and radiating numbness down the bilateral arms. His pain was rated 9 out of 10. The physical exam (8-5-2015) revealed midline cervical spine and bilateral trapezius region tenderness to palpation and spasms, decreased sensation in the bilateral C5-C7 (cervical 5-cervical 7) dermatomes, and bilateral upper extremities motor strength was 4+ out of 5. There were mildly hyper-reflexic reflexes in the bilateral upper extremities, positive bilateral Spurling's tests with symptoms radiating to the shoulder blade and tip of the shoulders, and a positive left Lhermitte's test. Per the treating physician (8-5-2015 report), an MRI of the cervical spine from 11-30-2012 revealed degenerative disc disease with facet arthropathy and retrolisthesis at C4-C5 (cervical 4-cervical 5) and C5-C6. There was severe central stenosis at C3-C4 (cervical 3-cervical 4), moderate at C4-C5, moderate to severe at C5-C6, and mild to moderate at C6-C7. There was moderate left C3-C4 neural foraminal narrowing, moderate to severe right and moderate left C4-C5, severe left and mild to moderate C5-C6, and mild left C6-C7. Treatment has included acupuncture, physical therapy, a home exercise program, and medications including oral pain, topical pain, proton pump inhibitor, and non-steroidal anti-inflammatory. Per the treating physician (8-5-2015 report), the injured worker has not worked since 2008. The requested treatments included an interlaminar epidural steroid injection C4-5 and C5-6. On 9-8-2015, the

original utilization review non-certified a request for an interlaminar epidural steroid injection C4-5 and C5-6.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interlaminar Epidural Steroid Injection C4-5 and C5-6: Overturned

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 8/5/15, physical exam revealed decreased sensation in the bilateral C5-C7 dermatomes, 4+/5 strength in the bilateral deltoids, biceps, internal rotators, external rotators, wrist extensors, wrist flexors, triceps, finger flexors, finger extensors, and interossei; mild hyperreflexia in the bilateral upper and lower extremities. MRI of the cervical spine dated 11/30/12 revealed at C4-C5 moderate central stenosis, and at C5-C6 moderate to severe central stenosis. I respectfully disagree with the UR physician's assertion that the documentation does not demonstrate findings consistent with radiculopathy. The request is medically necessary.