

Case Number:	CM15-0190602		
Date Assigned:	10/02/2015	Date of Injury:	06/11/2010
Decision Date:	11/10/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/28/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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:

This is a 53 year old female with a date of injury on 6-10-10. A review of the medical record indicates that the injured worker is undergoing treatment for chronic neck pain. Progress report dated 7-30-15 reports persistent cervical spine pain with radiation to the bilateral upper extremities, left greater than the right. She reports having a burning sensation in the cervical spine and she is having difficulty making a fist. Current pain regimen is Tramadol 50 mg, and cyclobenzaprine 10 mg. The pain medications help her to work and complete home exercise program. She reports having a previous cervical epidural steroid injection and that it provided over three months of reduction in her symptoms. She rates her pain at a 7 out of 10. Objective findings: she has tenderness to palpation and spasticity of the cervical paraspinals and over the cervical facet joints. Range of motion is limited mostly to the left side with left lateral flexion. Treatments include: medication, physical therapy, injections, nerve blocks and cervical fusion in 2011. Request for authorization was made for single cervical intralaminar epidural steroid injection with IV sedation at C7-T1 level. Utilization review dated 9-8-15 modified the request and certified for the procedure without IV sedation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Interlaminar ESI Under IV Sedation C6-7 or C7-T1: 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: The claimant sustained a work injury in June 2010 and underwent an anterior cervical decompression and fusion in 2011. She continues to be treated for neck pain with left upper extremity radiating symptoms. Prior to surgery she had an epidural injection reported to have provided more than three months of significant reduced symptoms. When seen, she had pain rated at 7/10. She was having radiating symptoms into the left greater than right upper extremity. Physical examination findings included decreased cervical spine range of motion. There was decreased grip strength bilaterally. There was tenderness and spasticity of the cervical paraspinals and over the cervical facet joint. Authorization is being requested for a cervical epidural injection with use of monitored anesthesia. The request references an aversion /anxiety to needles. An MRI of the cervical spine in November 2014 included findings of multilevel mild to moderate foraminal stenosis with right lateralization at C5/6. Criteria for the use of epidural steroid injections include radicular pain, defined as pain in dermatomal distribution with findings of radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, there are no physical examination findings such as decreased strength or sensation in a myotomal or dermatomal pattern or asymmetric reflex response that support a diagnosis of cervical radiculopathy. The claimant's left sided radicular complaints do not correlate with the right lateralized findings by MRI in November 2014. Moderate sedation is also being requested. There is no documentation of a medically necessary reason for monitored anesthesia during the procedure being requested. There is no history of movement disorder or poorly controlled spasticity such as might occur due to either a spinal cord injury or stroke. There is no history of severe panic attacks or poor response to prior injections. Having a dislike and anxiety related to needles would be a normal response to undergoing any invasive procedure. There is no indication for the use of sedation and this request is not medically necessary for this reason as well.