

Case Number:	CM15-0192656		
Date Assigned:	10/06/2015	Date of Injury:	01/04/2008
Decision Date:	11/19/2015	UR Denial Date:	09/17/2015
Priority:	Standard	Application Received:	09/30/2015

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 65 year old female, who sustained an industrial injury on 1-4-2008. Medical records indicate the worker is undergoing treatment for cervical and thoracic myoligamentous sprain-strain. A recent progress report dated 8-26-2015, reported the injured worker complained of bilateral shoulder pain, cervical pain and back pain rated 9 out of 10. Physical examination revealed cervical pain and muscle spasm along the cervical paraspinal muscles, cervical 6-7 dermatomes demonstrate decreased light touch sensation and cervical 2-6 revealed tenderness to palpation with spasm. Cervical magnetic resonance imaging from 2010 showed cervical 6-7 disc bulge. Treatment to date has included physical therapy and medication management, but no epidural steroid injections were noted. Pain medications were documented to provide 60% relief. On 8-26-2015, the Request for Authorization requested cervical epidural steroid injection. On 9-17-2015, the Utilization Review noncertified a request for a cervical epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical epidural steroid injection: Overturned

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 report dated 8/26/15, physical exam revealed decreased sensation about the C6-C7 dermatomes. MRI from 2010 showed C6-C7 1-2mm minimal disc annulus bulge with end plate ridging slightly indenting the thecal sac. Per progress report dated 3/2015, deep tendon reflexes of the upper extremities were +2/2 bilaterally in all muscle groups. There was trace weakness in the bilateral upper extremities. I respectfully disagree with the UR physician's assertion that imaging studies do not corroborate radiculopathy. Even though the requested level is not specified, the physical exam findings are corroborated by MRI findings indicating a C6-C7 radiculopathy. The standard of care is moving towards most cervical epidural steroid injections being performed with needle puncture at C7 for safety. The request is medically necessary.