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| Case Number: | CM15-0203071 | | |
| Date Assigned: | 10/19/2015 | Date of Injury: | 05/17/2013 |
| Decision Date: | 12/04/2015 | UR Denial Date: | 10/01/2015 |
| Priority: | Standard | Application Received: | 10/15/2015 |

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:

This is a 53-year-old female with a date of industrial injury 5-17-2013. The medical records indicated the injured worker (IW) was treated for degenerative disc disease, cervical; cervical radiculopathy, bilateral; and occipital neuralgia. In the progress notes (7-17-15), the IW reported right shoulder pain that radiated into the cervical area rated 8 out of 10, aggravated by heat, activity, sitting, standing and walking. On examination (7-17-15 notes), there was tenderness to the paracervical area. Range of motion was markedly limited. Tenderness was severe on both occipital areas, causing pain to radiate to the frontal area. Skin over the upper extremities was very sensitive. She was unable to move her head side to side. She had significant weakness in the upper extremities, particularly hand grip, bilaterally. Diffuse allodynia was present in the bilateral upper extremities in response to light touch and pin prick. Deep tendon reflexes were decreased but equal in the upper and lower extremities. In the 9-23-15 notes, the IW still had significant neck pain; the provider recommended an epidural steroid injection to determine the pain source. Treatments included Dilaudid, Flector patches, Gabapentin, Amrix and Cyclobenzaprine, cold, rest, massage and physical and occupational therapy (with benefit). She had a previous C5-6 cervical fusion. There was no documentation of a previous cervical epidural steroid injection. According to the Panel Qualified Medical Evaluation (4-13-15), electrodiagnostic testing done 1-19-15 of the bilateral upper extremities was normal. A Request for Authorization was received for a cervical epidural steroid injection. The Utilization Review on 10-1-15 non-certified the 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 steroid injection: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

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. MRI of the cervical spine (date unknown) revealed C5-C6 solid anterior fusion, no significant stenosis; C4-C5 moderate central canal stenosis and mild bilateral foraminal stenosis; C3-C4 mild central canal stenosis; C4-C5 and C6-C7 mild degenerative disc disease. Per physical exam dated 5/27/15, significant weakness of both upper extremities was noted; particularly hand grip on both sides. Sensory exam noted diffused cutaneous allodynia on both upper extremities. Deep tendon reflexes in the upper and lower extremities were decreased but equal. I respectfully disagree with the UR physician's assertion that MRI imaging did not reveal stenosis. The medical records do not indicate that the injured worker has previously been treated with epidural steroid injection. As the criteria are met, the request is medically necessary.