

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0218295 | | |
| Date Assigned: | 11/10/2015 | Date of Injury: | 09/30/2009 |
| Decision Date: | 12/29/2015 | UR Denial Date: | 10/09/2015 |
| Priority: | Standard | Application Received: | 11/05/2015 |

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 55-year-old female with a date of industrial injury 9-30-2009. The medical records indicated the injured worker (IW) was treated for chronic pain syndrome; spinal enthesopathy; neck pain; cervical radiculopathy; fasciitis, unspecified; thoracic outlet syndrome; and shoulder pain. In the progress notes (9-16-15), the IW reported neck pain radiating down into the bilateral shoulders and arms, rated 9 to 10 without medications, and 8 out of 10 with medications. Medications included OxyContin 40mg, Flexeril 10mg, Butrans patch 15mcg, Lunesta 1 mg, Norco 10mg and Nortriptyline 25mg. On examination (9-16-15 notes), there was tenderness over the cervical spine, the cervical paraspinals and the cervical facets at C5 to T1. Cervical loading maneuvers were positive. Spurling's test was positive on the left side only. Upper extremity sensation to sharp stimulus was decreased bilaterally. Deep tendon reflexes were decreased at the left biceps. Treatments included physical therapy, NSAIDs, TENS and medications for greater than six months; she also had an epidural steroid injection (4-2015) at left C5-6, which was beneficial, but the provider was not more specific. The notes (9-16-15) stated an MRI of the cervical spine on 9-16-13 showed multiple herniated discs, most remarkable at C5-C6 with moderate left and minimal right foraminal stenosis. Repeat left C5-C6 epidural steroid injection was recommended; there was no documentation of the level of efficacy or duration of relief provided by the previous injection. A Request for Authorization was received for one left C5-C6 epidural steroid injection. The Utilization Review on 10-9-15 non-certified the request for one left C5-C6 epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left C5-C6 epidural steroid injection qty: 1.00: Upheld

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. Per progress report dated 9/16/15, it was noted that upper extremity sensation to sharp stimulus was decreased bilaterally. Deep tendon reflexes were decreased at the left biceps. MRI of the cervical spine showed multiple herniated discs, most remarkable at C5-C6 with moderate left and minimal right foraminal stenosis. It was noted that the injured worker was previously treated with epidural steroid injection 4/2015, however, there was no documentation of the specific amount of pain relief provided, duration of effects, or associated reduction in medication use for six to eight weeks. Absent such, the request is not medically necessary.