

Case Number:	CM15-0042200		
Date Assigned:	03/12/2015	Date of Injury:	12/08/2010
Decision Date:	04/23/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	03/05/2015

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
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 58 year old male patient, who sustained an industrial injury on 12/08/2010. A primary treating office visit dated 02/16/2015, reported subjective chief complaint of neck pain that radiates to the posterior neck, to left arm and forearm. He reports dropping objects out of both hands. The following diagnoses are applied acquired spondylolithesis; displace thoracic intervert disc; brachial neuritis and spinal stenosis cervical region. The plan of care involved proceeding with cervical epidural steroid injection to C5-6 and C3-4 and follow up in one month.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical epidural steroid injection at C3-4 and C5-6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter, ESI.

Decision rationale: Based on the 2/16/15 progress report provided by the treating physician, this patient presents with neck pain radiating posterior neck to left arm/forearm. The treater has asked for CERVICAL EPIDURAL STEROID INJECTION AT C3-4 AND C5-6 but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient is s/p anterior cervical discectomy/foraminotomies, and spinal canal decompression from 2/12/13 per 2/16/15 report. The patient was treated with a neck brace, electric bone growth stimulator and 6 weeks of physical therapy postoperatively per 2/16/15 report. A repeat MRI scan of C-spine was done on November 2013 and no deterioration of neck from prior MRI of C-spine from 12/28/12. The patient is dropping objects such as coffee cups from both hands per 2/16/15 report. Review of the reports do not show any evidence of cervical epidural steroid injections being done in the past. The patient's work status is permanent and stationary, has work restrictions, but no evidence of return to work. MTUS page 46, 47 states that an ESI is "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." MTUS further states, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." For post-op, ODG guidelines L-spine chapter under ESI states, "Not recommended post-op. The evidence for ESI for post lumbar surgery syndrome is poor." Review of the reports do not show any evidence of cervical epidural steroid injections being done in the past. The treater does not discuss this request in the reports provided. Per 8/1/14 AME report, a cervical MRI dated 10/29/14 showed 2mm disc bulge at C3-4 with bilateral arthropathy effacing dorsal subarachnoid space, causing central canal stenosis and cord compression with AP dimension in midline measuring 6mm. At C5-6, 1mm anterolisthesis. At C6-7, anterior discectomy with solid fusion of vertebral dissection by anterior plate/screws in normal alignment." In this case, the patient has neck pain radiating into the left upper extremity but MRI's are negative with no potential nerve root lesions. 1-2mm bulging discs are normal findings. There is lack of a clear diagnosis of radiculopathy which require corroborating imaging findings showing nerve root lesion. Furthermore, the patient is s/p cervical discectomy/fusion at C6-7, and ODG does not recommend an epidural steroid injection when the patient has had spinal surgery unless there is a new lesion. According to MTUS, "there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain." The request IS NOT medically necessary.

4 View X-ray of the cervical spine: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Neck & upper back chapter: Radiography (X-rays).

Decision rationale: Based on the 2/16/15 progress report provided by the treating physician, this patient presents with neck pain radiating posterior neck to left arm/forearm. The treater has asked for 4 VIEW X-RAY OF THE CERVICAL SPINE on 2/16/15. The treater does not discuss

this request in the requesting progress report. The request for authorization was not included in provided reports. The patient is s/p anterior cervical discectomy/foraminotomies, and spinal canal decompression from 2/12/13 per 2/16/15 report. The patient was treated with a neck brace, electric bone growth stimulator and 6 weeks of physical therapy postoperatively per 2/16/15 report. A repeat MRI scan of C-spine was done on November 2013 and no deterioration of neck from prior MRI of C-spine from 12/28/12. The patient is dropping objects such as coffee cups from both hands per 2/16/15 report. Review of the reports do not show any evidence of cervical epidural steroid injections being done in the past. The patient's work status is permanent and stationary, has work restrictions, but no evidence of return to work. Regarding cervical x-rays, ODG states supports it for post-surgery evaluation of fusion among other reasons. The treater does not discuss this request in the reports provided. In this case, the patient is 3 years removed from his cervical fusion surgery. Review of the reports do not show any evidence of cervical X-rays being done in the past. As the patient is still symptomatic with persistent cervical pain, the treater appears to be requesting an X-ray to evaluate the status of the fusion which is reasonable and within ODG guidelines. Given the lack of an X-ray post fusion surgery within the past 3 years, the request IS medically necessary.