

Case Number:	CM15-0045339		
Date Assigned:	03/18/2015	Date of Injury:	03/04/2000
Decision Date:	04/23/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/10/2015

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, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 54-year-old female, who sustained an industrial injury on 3/4/00. She has reported neck and right shoulder injury. The mechanism of injury was not noted. The diagnoses have included chronic right shoulder pain, cervicgia, myalgia and myositis, chronic right sided neck pain status post C5-C7 anterior cervical discectomy and fusion. Treatment to date has included medications, physical therapy, injections, surgery and Home Exercise Program (HEP). Currently, as per the physician progress note dated 1/22/15, the injured worker complains of center posterior neck pain rated 7/10 on pain scale. She states the pain was occasional and described as aching and stabbing pain. The pain radiates to the right arm, fingers, forearm, hand, shoulder and right shoulder blade. The pain is alleviated with medications, stretching, applying heat while neck movement and prolonged sitting aggravate the condition. She also states that she has stiffness and tightness in the neck at times. The cervical spine exam revealed positive foraminal compression test bilaterally. Magnetic Resonance Imaging (MRI) of the cervical spine dated 8/21/12 revealed disc protrusion with mild impingement C6-7. It was noted that the injured worker's symptoms were largely unchanged. The symptoms are worsened with activities of daily living (ADL's) and her activities of daily living (ADL's) are impaired. The current medication she used for pain was Tramadol and transdermal creams. Work status was temporary totally disabled for the next 6 weeks.

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 C7-T1 under MAC sedation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Epidural steroid injections.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, cervical epidural steroid injection at C7 - T-1 under MAC sedation is not medically necessary. Epidural steroid injections are recommended as an option for treatment of radicular pain. The criteria are enumerated in the Official Disability Guidelines. The criteria include, but are not limited to, radiculopathy must be documented by physical examination and corroborated by imaging studies and or electrodiagnostic testing; initially unresponsive to conservative treatment (exercises, physical methods, non-steroidal anti-inflammatory's and muscle relaxants); 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 6 to 8 weeks, etc. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications and functional response. etc. See the guidelines for details. There is no evidence-based literature to make a firm recommendation as to sedation during the SI. The use of sedation introduces potential diagnostic and safety issues making it unnecessary rather than ideal. A major concern is that sedation may result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. Routine use is not recommended except for patients with anxiety. The general agent recommended is a benzodiazepine. While sedation is not recommended for facet injections (especially with opiates) because it may alter the anesthetic diagnostic response, sedation is not generally necessary for an epidural steroid injection is not contraindicated. In this case, the injured worker's working diagnoses are S/P ACDF; cervical myalgia; and rotator cuff. The most recent progress note in the medical record is dated September 15, 2014. The request for authorization for the cervical epidural steroid injection is February 23, 2015. There are no contemporaneous progress notes in the medical record written on or about February 23, 2015. There is no documentation in the medical record with a clinical indication or rationale for MAC sedation. Sedation is generally not necessary for an epidural steroid injection. As noted above, there are no contemporaneous progress notes with a clinical indication, rationale or past medical history on or about February 23, 2015. The progress note dated September 15, 2014 did not contain a detailed physical examination or a neurologic evaluation demonstrating objective evidence of radiculopathy. Additionally, MRI evaluation of the lumbar spine did not show any nerve impingement or corroborate signs of radiculopathy. Consequently, absent clinical documentation with the need for epidural steroid sedation in the absence of objective evidence of radiculopathy and MRI evidence of corroborating radiculopathy in a progress note dated September 15, 2014, cervical epidural steroid injection at C7 - T-1 under MAC sedation is not medically necessary.

Pre-op medical clearance to include: H&P, EKG, chest X-ray and labs: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.aafp.org/afp/2013/0315/p414.html>.

Decision rationale: Pursuant to the American Academy of Family Physicians, preoperative medical clearance with history, physical examination, EKG, chest x-ray and laboratories are not medically necessary. Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. In this case, the injured worker's working diagnoses are S/P ACDF; cervical myalgia; and rotator cuff. The most recent progress note in the medical record is dated September 15, 2014. The request for authorization for the cervical epidural steroid injection is February 23, 2015. There are no contemporaneous progress notes in the medical record written on or about February 23, 2015. There is no documentation in the medical record with a clinical indication or rationale for MAC sedation. Sedation is generally not necessary for an epidural steroid injection. As noted above, there are no contemporaneous progress notes with a clinical indication, rationale or past medical history on or about February 23, 2015. The progress note dated September 15, 2014 did not contain a detailed physical examination or a neurologic evaluation demonstrating objective evidence of radiculopathy. Additionally, MRI evaluation of the lumbar spine did not show any nerve impingement or corroborate signs of radiculopathy. Consequently, absent clinical documentation with the need for epidural steroid sedation in the absence of objective evidence of radiculopathy and MRI evidence of corroborating radiculopathy in a progress note dated September 15, 2014, cervical epidural steroid injection at C7 - T-1 under MAC sedation is not medically necessary. Consequently, absent clinical documentation with a clinical indication and rationale for performing an ESI under MAC sedation, preoperative medical clearance with history, physical examination, EKG, chest x-ray and laboratories are not medically necessary.