

Case Number:	CM15-0232788		
Date Assigned:	12/08/2015	Date of Injury:	07/19/2012
Decision Date:	01/11/2016	UR Denial Date:	11/09/2015
Priority:	Standard	Application Received:	11/25/2015

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: Preventive Medicine, Occupational 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 47 year old female, who sustained an industrial injury on July 19, 2012. The injured worker was diagnosed as having chronic pain other, cervical facet arthropathy, cervical radiculopathy, headaches, cervicgia and migraine unspecified, not intractable, and without status migrainosus, and status post carpal tunnel release on the right. Treatment and diagnostic studies to date has included multi-positional magnetic resonance imaging of the cervical spine October 01, 2012, magnetic resonance imaging of the right elbow, acupuncture, status post bilateral cervical 4 to 6 epidural on May 30, 2014, sleep study performed November 25, 2013, and electromyogram with nerve conduction study performed on August 17, 2012. In a progress note dated September 14, 2015 the treating physician reports complaints of pain to the neck that radiates to the bilateral upper extremities with the left greater than the right along with numbness to the bilateral upper extremities to the hands. The treating physician also noted pain to the lower extremities to the knees and frontal and occipital migraine headaches. Examination performed on September 14, 2015 was revealing for tenderness to the cervical spine at cervical 4 to 6, tenderness to the cervical paravertebral muscles at cervical 4 to 7 region, decreased range of motion to the cervical spine with pain, decreased strength to the extensor and flexor muscle bilaterally, tenderness to the right wrist, and decreased range of motion to the right wrist with pain. The injured worker's pain level was rated a 6 out of 10 with the use of her medication regimen and rated the pain level an 8 out of 10 without the use of her medication regimen. On September 14, 2015 the treating physician noted multi-positional magnetic resonance imaging of the cervical spine performed on October 01, 2012 that was revealing for disc desiccation at

cervical 3 to 4 and cervical 4 to 5, diffuse disc protrusion at cervical 3 to 4, cervical 4 to 5, and cervical 5 to 6 effacing the thecal sacroiliac, and grade I retrolisthesis of cervical 4 over cervical 5. The treating physician also noted an electromyogram with nerve conduction study report from August 17, 2012 that was revealing for an abnormal nerve conduction study "suggestive of a mild bilateral carpal tunnel syndrome" and also noted a normal electromyogram. The progress note on September 14, 2015 noted that the injured worker was status post cervical epidural steroid injection to the bilateral cervical 4 to 6 levels on May 30, 2014 and had 50 to 80% improvement post procedure with a decrease in the use of the injured worker's medication regimen and improved mobility that lasted 5 months after procedure. On September 14, 2015 the treating physician requested bilateral cervical 4 to 6 epidural steroid injection under fluoroscopy noting that the injured worker had prior cervical epidural steroid injection and noted that the injured worker had "positive response" as noted above. On the Utilization Review denied the request for bilateral cervical 4 to 6 epidural steroid injection under fluoroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral C4-6 epidural steroid injection under fluoroscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Online Version 2013, Neck and Upper Back Chapter, Epidural Steroid Injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper Back/Epidural injections.

Decision rationale: MTUS Guidelines have specific criteria to justify the use of epidural steroid injections. These include a well defined dermatomal radiculopathy that corresponds to diagnostic testing (MRI and/or electrodiagnostics). The MTUS standards also state that up to a maximum of 2 nerve roots or 1 level inter-laminar injection are recommended. Even though a prior response is reported, this request does not meet Guideline standards. A specific radiculopathy that corresponds with testing is not documented. Electrodiagnostics were negative for a radiculopathy and the MRI studies supported a nerve root compromise only at the left sided C5-C6. In addition, the updated ODG Guidelines do not recommend cervical epidural injections due to risk of injury and limited benefit. There are no unusual circumstances to justify an exception to Guideline recommendations. The Bilateral C4-6 epidural steroid injection under fluoroscopy is not supported by Guidelines and is not medically necessary.