

Case Number:	CM13-0044411		
Date Assigned:	12/27/2013	Date of Injury:	10/18/2008
Decision Date:	02/27/2014	UR Denial Date:	10/21/2013
Priority:	Standard	Application Received:	10/29/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Oklahoma and Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 65-year-old male who reported an injury on 10/18/2008. The mechanism of injury was stated to be the patient had a fall from a ladder. The patient was noted to have an MRI on 07/03/2013, which revealed at the level of C5-6 annular concentric and broad based bilateral lateral 4.2 mm disc protrusion with flattening and abutting of the anterior right more than left portion of the thecal sac with mild to moderate right more than left lateral spinal and neural foraminal stenosis. There was no extrusion or sequestration of disc material and no cord compression. At C6-7 there was annular concentric right more than left paracentral 4 mm disc protrusion with flattening and abutting of the anterior right more than left portion of the thecal sac extending to the anterior subarachnoid space with mild to moderate more right than left lateral spinal and neural foraminal stenosis with no extrusion or sequestration of disc material and no cord compression was seen. The patient's physical examination revealed moderate discomfort, severe reduced spinal range of motion, and a positive Spurling's and axial head compression test bilaterally. The patient's diagnosis was noted to be cervical sprain/strain with underlying multilevel cervical spondylosis. The request was made for a cervical interlaminar epidural at C5-6 level.

IMR ISSUES, DECISIONS AND RATIONALES

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

cervical interlaminar epidural steroid injection at C5-6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: California MTUS guidelines recommend for an epidural steroid injection that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing and it must be initially unresponsive to conservative treatment. The clinical documentation submitted for review indicated the patient had radicular findings upon physical examination and it was corroborated by imaging studies; however, there was a lack of documentation indicating the patient was initially unresponsive to conservative treatment. Given the above, the request for cervical interlaminar epidural steroid injection at C5-6 is not medically necessary.