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| Case Number: | CM14-0094978 | | |
| Date Assigned: | 09/15/2014 | Date of Injury: | 02/01/2010 |
| Decision Date: | 10/06/2014 | UR Denial Date: | 06/09/2014 |
| Priority: | Standard | Application Received: | 06/23/2014 |

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/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:

There were 334 pages provided for this review. The application for independent medical review was signed on June 14, 2014. The goods or services in question were the non-certification of a second bilateral transforaminal lumbar epidural steroid injection at L4-five and L5-S1 under fluoroscopic guidance and the non-certification of the second cervical epidural steroid injection at C7-T1 under fluoroscopic guidance. Per the records provided, he is a 61-year-old man who was injured on February 1, 2010. He had been diagnosed with bilateral shoulder impingement syndrome right worse than left, partial to complete tear of the right rotator cuff with osteoarthritis of the acromioclavicular joint, bilateral carpal tunnel syndrome, bilateral ulnar nerve neuritis, and cubital tunnel syndrome, mild subluxation of the ulnar nerve, cervical spine strain sprain with discogenic disease, lumbar spine sprain and left knee internal derangement. An MRI of the right shoulder on August 23, 2010 showed infraspinatus tendinitis, bicipital tenosynovitis, acromioclavicular osteoarthritis and subacromial sub deltoid bursitis. The MRI of the left shoulder on the same date showed a partial thickness tear involving the supraspinatus tendon at its insertion, tendinitis and intramuscular ganglion cyst within the subscapularis. The MRI of the left knee also done on the same date and it showed an oblique tear of the posterior horn of the medial meniscus, tricompartmental osteoarthritic change and a Baker's cyst. An EMG NCV of the lower extremities was normal. The studies of the upper extremities done on September 2, 2010 showed a left carpal tunnel syndrome and bilateral ulnar entrapment. Future medical care was permitted for the cervical spine to include orthopedic evaluations, oral anti-inflammatory medicine possible bilateral shoulder arthroscopy, possible bilateral cubital tunnel syndrome surgery, possible left carpal tunnel release surgery and possible left knee arthroscopy with a series of Synvisc injections and an abbreviated course of physical therapy. An MRI of the lumbar spine was done on March 29, 2012 that showed largely degenerative changes with neural

foraminal encroachment. There was a broad-based disc protrusion seen at L4-L5. An MRI of the cervical spine showed C5-C6 disc disease which caused a mild central spinal canal stenosis and foraminal stenosis, moderate on the right and mild on the left as well as C4-C5 foraminal stenosis moderate on the right and left and it C3 for foraminal stenosis moderate on the right and left. At C6 seven the foraminal stenosis is moderate on the right. The patient had previous bilateral L4-L5 and L5-S1 transforaminal injections. One was done to the lumbar area just three weeks ago. He underwent a cervical epidural on March 12, 2014 with 50% improvement. The records do not attested the duration of pain relief or evidence of decreased medicine use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Second bilateral transforaminal lumbar epidural steroid injection at L4-5 and L5-S1 under fluoroscopy guidance: 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 Page(s): 47.

Decision rationale: The MTUS recommends this as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). In this case, the MTUS criterion "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing" is not met. Further, the criterion for repeat ESI is at least 6-8 weeks of pain and improvement in function for 6-8 weeks following injection, and the outcomes from previous ESI do not meet this criterion.

Second Cervical Epidural Steroid Injection at C7-T1 under fluoroscopy guidance: 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 Page(s): 47.

Decision rationale: As shared previously, the MTUS recommends this as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). In this case, the MTUS criterion "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing" is not met. Further, the criterion for repeat ESI is at least 6-8 weeks of pain and improvement in function for 6-8 weeks following injection, and the outcomes from previous ESI do not meet this criterion.

