Case Number:	CM15-0123827		
Date Assigned:	07/08/2015	Date of Injury:	04/16/2010
Decision Date:	08/04/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	06/26/2015

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 56 year old male, who sustained an industrial injury on 4/16/2010. Diagnoses include possible finger radicular pain. Treatment to date has included conservative treatment consisting of diagnostics, neck traction, physical therapy and medications including Lyrica and Fenofibrate. Per the most recent submitted Primary Treating Physician's Progress Report dated 4/03/2015, the injured worker reported elbow, hip and knee pain. There has been no change in neck pain and he reports tingling in his fingers of the right hand. Physical examination of the cervical spine revealed no tenderness and normal range of motion. He experiences some tingling sensation to the tip of the 2nd, 3rd and 4th fingers with extension of his neck. The rest of the exam is described as normal. The plan of care included medications and follow-up care. Authorization was requested on 6/09/2015 for C5-6 transforaminal epidural steroid injection, C5-6 Interlaminar epidural steroid injection, and magnetic resonance imaging (MRI) of the thoracic spine without contrast.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical C5-C6 Transforaminal Epidural Steroid Injection, Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back - Epidural steroid injection (ESI).

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

Decision rationale: The MTUS Guidelines recommend the use of epidural steroid injections (ESIs) as an option for treatment of radicular pain. Radicular pain is defined as pain in dermatomal distribution with corroborative findings of radiculopathy. Research has shown that less than two injections are usually required for a successful ESI outcome. A second epidural injection may be indicated if partial success is produced with the first injection, and a third ESI is rarely recommended. ESI can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The treatment alone offers no significant long-term functional benefit. Criteria for the use of ESI include radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, and failed conservative treatment. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medications use for six to eight weeks. In this case, radiculopathy is not documented on physical exam and there is a lack of evidence supporting failure with conservative treatment. The request for Cervical C5-C6 Transforaminal Epidural Steroid Injection, Qty 1 is determined to not be medically necessary.

Cervical C5-C6 Interlaminar Epidural Steroid Injection, Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back - Epidural steroid injection (ESI).

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

Decision rationale: The MTUS Guidelines recommend the use of epidural steroid injections (ESIs) as an option for treatment of radicular pain. Radicular pain is defined as pain in dermatomal distribution with corroborative findings of radiculopathy. Research has shown that less than two injections are usually required for a successful ESI outcome. A second epidural injection may be indicated if partial success is produced with the first injection, and a third ESI is rarely recommended. ESI can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The treatment alone offers no significant long-term functional benefit. Criteria for the use of ESI include radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, and failed conservative treatment. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medications use for six to eight weeks. In this case, radiculopathy is not documented on physical exam and there is a lack of evidence supporting failure with conservative treatment. The request for Cervical C5-C6 Interlaminar Epidural Steroid Injection, Qty 1 is determined to not be medically necessary.

MRI (magnetic resonance imaging) Thoracic Spine, without contrast, Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back, Lumbar & Thoracic (Acute & Chronic) - MRIs (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: Regarding thoracic MRI, the MTUS guidelines state that physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. In this case, there are no thoracic symptoms documented on physical exam and there were no x-rays of the thoracic spine available for review. The request for MRI (magnetic resonance imaging) Thoracic Spine, without contrast, Qty 1 is determined to not be medically necessary.