

Case Number:	CM15-0070566		
Date Assigned:	04/20/2015	Date of Injury:	01/07/2000
Decision Date:	05/19/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	04/14/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 46 year old female sustained an industrial injury on 1/7/2000. She subsequently reported low back pain. Diagnoses include cervicgia and cervical radiculitis. Treatments to date have included x-rays, MRIs, nerve conduction study, acupuncture, physical therapy, surgeries and prescription pain medications. The injured worker continues to experience upper back pain with radiation to the bilateral upper extremities. A request for Cervical Epidural/Fluoroscopic Guidance Right C7-T1 and post op follow up visit was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post Op Follow Up Qty 1.00: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Office visits.

Decision rationale: The claimant has a remote history of a work injury occurring more than 15 years ago. Treatments included a multilevel cervical fusion done in July 2013. When seen, she was having severe neck and bilateral upper extremity pain. Physical examination findings included positive Spurling's testing. Imaging results were reviewed with an MRI in December 2014 including findings of adjacent segment degeneration below the level of the fusion including findings of a right lateralized C6 osteophyte with foraminal narrowing. The referring provider documents decreased right upper extremity sensation. Office visits are recommended as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. This request is for follow-up after an epidural steroid injection which is medically necessary.

Cervical Epidural/Fluoroscopic Guidance Right C7-T1 Qty 1.00: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections, p46.

Decision rationale: The claimant has a remote history of a work injury occurring more than 15 years ago. Treatments included a multilevel cervical fusion done in July 2013. When seen, she was having severe neck and bilateral upper extremity pain. Physical examination findings included positive Spurling's testing. Imaging results were reviewed with an MRI in December 2014 including findings of adjacent segment degeneration below the level of the fusion including findings of a right lateralized C6 osteophyte with foraminal narrowing. The referring provider documents decreased right upper extremity sensation. Criteria for the use of epidural steroid injections include that radiculopathy be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, the claimant's providers document positive neural tension signs and decreased right upper extremity sensation and imaging has shown findings consistent with the presence of radiculopathy. Prior conservative treatments have included physical therapy and medications. The criteria are met and the requested epidural steroid injection is therefore considered medically necessary.