

Case Number:	CM13-0014995		
Date Assigned:	03/10/2014	Date of Injury:	06/20/2007
Decision Date:	04/17/2014	UR Denial Date:	08/09/2013
Priority:	Standard	Application Received:	08/21/2013

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 Preventive 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:

The patient is a 57 year old female who was injured on 06/20/2007 due to a fall. Prior treatment history has included unresponsive conservative treatment (exercises, physical methods, NSAIDs, and muscle relaxants). An MRI of the cervical spine dated 09/02/2011 indicated there is mild accentuation of the cervical lordosis at the C3 through C5 levels and mild straightening of the lordotic curvature below that level possibly related to degenerative disc disease. At C4-5 there may be a tiny central and left paracentral protrusion measuring approximately 1mm in thickness with no significant central stenosis or lateral recess encroachment. There is moderate to marked right-sided hypertrophic facet arthropathy that does not appear to contribute to any significant right-sided foraminal narrowing. There is very mild left-sided facet arthropathy with no more than minimal left-sided foraminal narrowing. At C5-6 there is small to moderate sized broad based central and right paracentral disc protrusion suspicious for a contained herniation measuring 2-3 mm in anteroposterior thickness with 2-3 mm cranial extension of disc material. Mild ligamentum flavum hypertrophy posteriorly contributes to mild central stenosis with narrowing of the central canal to approximately 8.5 to 9 mm midline AP. There is slight encroachment upon the right lateral recess with no significant left bilateral recess encroachment foraminal narrowing. Mild to moderate facet arthropathy is noted bilaterally. An EMG/NCV dated 09/13/2013 indicated evidence of moderately severe right carpal tunnel syndrome (medial nerve entrapment at wrist) affecting sensory and motor components. The electrodiagnostic study reveals evidence of mild chronic degenerative changes at C7 nerve root level. Consider MRI of the C-spine for further evaluation. QME note dated 05/20/2013 documented deep tendon reflexes are 2+ in the upper and lower extremities. Sensation was not documented for upper extremities. Progress report dated 08/02/2013 documented the patient with persistent pain in the neck. Level of pain is 6-9/10. Objective findings on exam included moderate tenderness to palpation in both

the cervical spine. There was hyperesthesias in bilateral upper extremities. Progress report dated 07/02/2013 documented the patient with complaints of neck pain radiating down to the bilateral upper extremities. The level of pain was 6-8/10. Objective findings on exam included tenderness to palpation of the cervical paraspinal musculature. There was limited flexion due to pain in the cervical spine. Progress report dated 09/23/2013 documented the patient with complaints of increased pain of the bilateral upper extremities. She reports a moderate amount of pain in the right arm distal to the elbow all the way to her fingertips. The level of pain is 7/10. Objective findings on exam include a positive Phalen and positive Tinel's sign of the right upper extremity. She was approved for PUSH therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL EPIDURAL STEROID INJECTION AT C4, C5, AND C6 WITH IV SEDATION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS Page(s): 46.

Decision rationale: According to the MTUS Chronic Pain Guidelines, ESIs are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The medical records document that the patient has neck pain, upper extremities hyperesthesia and tenderness to palpation, but there was no documented specific dermatomal deficit on clinical exam. In the absence of documented radiculopathy, the request does not meet the MTUS Chronic Pain Guidelines' criteria for epidural steroid injections. The request is not medically necessary and appropriate.