

<b>Case Number:</b>	CM13-0028063		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	09/21/2011
<b>Decision Date:</b>	01/29/2014	<b>UR Denial Date:</b>	09/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2013

### 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 47-year-old female who reported an injury on 09/21/2011. The mechanism of injury was not provided for review. The patient was initially treated with physical therapy. An MRI revealed a central disc protrusion of the C6-7 indenting on the anterior thecal sac. The patient underwent an EMG/NCV that revealed evidence of bilateral ulnar neuropathy; however, no evidence of cervical radiculopathy. The patient underwent left cubital tunnel release with anterior subcutaneous transposition of the ulnar nerve. The patient's most recent clinical exam findings included tenderness to palpation over the lateral epicondyle with a positive Cozen test, and normal cervical range of motion with intact sensation of the bilateral upper extremities and a negative Spurling's sign. It is also noted that the patient has diminished deep tendon reflexes of the right biceps tendon and triceps tendon rated at a 2/4. The patient's diagnosis included right lateral epicondylitis and cervical radiculitis. The patient's treatment plan included a cervical epidural steroid injection followed by physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the cervical spine, 1-2 times a week for six weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter, Physical Medicine.

**Decision rationale:** The requested physical therapy for the cervical spine 1 to 2 times a week for 6 weeks is not medically necessary or appropriate. The clinical documentation submitted for review does not provide evidence that the patient would benefit from an epidural steroid injection. It is noted within the documentation that prior physical therapy provided an increase in pain; and therefore, had to be discontinued. Although Official Disability Guidelines would recommend 1 to 2 visits after an epidural steroid injection to re-establish a home exercise program, an epidural steroid injection is not supported at this time. As the patient failed to respond to previous physical therapy treatments, continuation would be indicated. California Medical Treatment Utilization Schedule recommends continuation of therapy be supported by significant functional benefit. As there was no significant functional benefit from the prior treatment, continuation of treatment would be supported. As such, the requested physical therapy for the cervical spine 1 to 2 times week for 6 weeks is not medically necessary or appropriate.

**C7-T1 interlaminar epidural injection with fluroscopy:** 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:** The requested C7-T1 interlaminar epidural steroid injection with fluoroscopy is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has decreased reflexes in the C7 dermatome. However, the imaging study provided for review does not provide any pathology in the C7-T1 level. As the physical findings do not correlate with the imaging studies, an epidural steroid injection would not be supported. As such, the requested C7-T1 interlaminar epidural steroid injection with fluoroscopy is not medically necessary or appropriate.