

<b>Case Number:</b>	CM13-0054458		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	01/09/2006
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	10/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2013

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pediatric Rehabilitation Medicine and is licensed to practice in 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 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 53-year-old female who reported an injury on 01/09/2006. The mechanism of injury was not provided. The patient was diagnosed with left cervical radiculopathy, central and left foraminal disc protrusion, moderate neural foraminal stenosis, cervical facet joint arthropathy, cervical sprain and non-industrial hypertension. The patient was seen by [REDACTED] on 10/07/2013. The patient reported 8/10 pain. Physical examination on that date revealed restricted range of motion, positive provocative maneuvers, spasm of the left trapezius region, positive Spurling's maneuver on the left and diminished strength in the left biceps, left pronator teres and left wrist extensors. Treatment recommendations included a repeat fluoroscopically-guided left C4-5 and left C5-6 transforaminal epidural steroid injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **REPEAT FLUOROSCIPALLY-GUIDED LEFT C4-5 AND C5-6 TRANSFORAMINAL EPIDURAL STEROID INJECTION: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

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

**Decision rationale:** The California MTUS Guidelines state that epidural steroid injections are recommended as an option for the treatment of radicular pain, with use in conjunction with other rehab efforts. As per the documentation submitted, the patient previously underwent a C4-5 and C5-6 transforaminal epidural injection, which provided 80% relief for 4 to 6 months. However, there was no documentation of objective functional improvement with an associated reduction of medication use for 6 to 8 weeks following the initial injection. Therefore, a repeat injection cannot be determined as medically appropriate. There were also no imaging studies or electrodiagnostic reports submitted for review. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.