

<b>Case Number:</b>	CM13-0058218		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	08/04/2007
<b>Decision Date:</b>	08/08/2014	<b>UR Denial Date:</b>	10/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2013

### 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 Occupational 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 was injured on 08/04/07 and was diagnosed with carpal tunnel syndrome and cervical radiculitis. A C5-6 translaminar epidural steroid injection is under review. Cervical MRI on 07/27/11 revealed mild central stenosis at C4-5 and C5-6 with no significant cord compression. There was multilevel neural foraminal stenosis. The patient had previously had ESIs on 01/03/12 and 03/02/12. She saw [REDACTED] on 07/25/13 and had cervical, shoulder, and bilateral upper extremity injuries. She had chronic cervical-scapular pain at level C6-7 with radiation to the bilateral upper extremities and also pain and numbness in both hands. She is status post bilateral carpal tunnel releases with residual symptoms. Physical examination revealed decreased range of motion of the cervical spine and localized tenderness with negative Spurling's on both sides. There was no active synovitis but she had positive Tinel's and Phalen's of the bilateral wrists and decreased pinprick in the bilateral median distributions but no other focal neurologic deficits. Translaminar cervical epidural steroid injection was recommended along with home exercises and medication. On 10/07/13, she continued to complain of frequent cervical scapular pain radiating to the entire bilateral upper extremities with tingling and numbness in both hands. She had suboccipital intractable headaches and anxiety and was in moderate distress. Range of motion was decreased by 50%. She had negative Spurling's. There was positive Tinel's and Phalen's. There were no neurologic deficits other than decreased pinprick in the bilateral median distributions. She was referred again for a C5-6 translaminar epidural steroid injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**C5-6 TRANSLAMINAR ESI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 79.

**Decision rationale:** The history and documentation do not objectively support the request for a cervical ESI at this time. The MTUS state ESI may be recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Criteria for the use of Epidural steroid injections: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). There is no clear objective evidence of radiculopathy on physical examination and no EMG was submitted. Diagnoses of carpal tunnel syndrome and radiculitis have been noted in the records but not radiculopathy. In addition, there is no evidence of radiculopathy by physical examination or EMG that is consistent with the MRI results. The MRI did not reveal nerve root compression at the level to be injected. It is not clear whether the patient has been instructed in home exercises to do in conjunction with injection therapy. The results of the ESIs in 2012 are not known, including whether or not measurable functional recovery occurred, the degree of pain relief, or the duration. The medical necessity of this request has not been clearly demonstrated.