

<b>Case Number:</b>	CM13-0059950		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/02/2000
<b>Decision Date:</b>	03/27/2014	<b>UR Denial Date:</b>	11/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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 Orthopedic Surgery, 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 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 57 year old female who was injured on 10/02/2000 while moving trays of food when she was injured. She felt her muscle pulled in her left shoulder. She was prescribed Norco. The patient was seen on 03/28/2013 and on 04/25/2013 for an office visit with [REDACTED], [REDACTED] for medication refills. The patient had pain located in neck, scapula. Pain was described as burning, severity 4/10, constant and daily. Associated signs and symptoms were numbness bilaterally. An improving factor was lying down. Aggravating factors were twisting, reaching, and bending. Treatment history included muscle relaxants, physical therapy, injections, surgery, massage therapy, ice, and daily exercise. Prior surgery history includes; anterior cervical discectomy and fusion from C5-C7. Cervical MRI performed 04/25/2013 revealed evidence of prior anterior fusion instrumentation consisting of a plate and screws through C5, C6, C7 causing local regional artifact. The vertebral body alignment is anatomic. The vertebral body heights are maintained. There was mild multi level degenerative disc disease at C3-4, C4-5, and C7-T1. C2-3 had no significant posterior disc herniation, central canal or neuroforaminal narrowing. C3-4, revealed posterior disc protrusion without significant central canal or neural foramina narrowing. C4-5 revealed a right foraminal disc protrusion resulting in a moderate right neuroforaminal narrowing. No significant left neuroforaminal narrowing or central canal narrowing. C6-6 revealed no significant central canal or left neuroforaminal narrowing. Right facet osteoarthritis resulting in severe right neural foraminal narrowing. C6-7 revealed bilateral uncovertebral hypertrophy resulting in mild and moderate left neuroforaminal narrowing. No significant central canal narrowing. C7-T1 revealed no significant posterior disc herniation, central canal or neuroforaminal narrowing. T1-2, T2-3, T3-4 revealed no significant posterior disc, herniation, central canal or neural foraminal narrowing. Clinic note dated 12/5/2013 indicates that patient presented with complains of pain in neck, thoracic region posteriorly

radiating to right scapula and left scapula on physical exam there was loss of cervical lordosis ROM moderately decreased with flexion right lateral bending and left lateral bending. On palpation there was moderate tenderness to cervical paraspinous muscles right >left. No facet joints tenderness was noted. Shoulder region had tenderness over trapezius muscle. Motor exam was normal bilateral strength 5/5 in the upper extremities. Sensory exam showed decreased sensation in bilateral, thumbs and digits. Reflex exam showed diminished biceps, brachioradialis and triceps bilaterally. Diagnoses include post-laminectomy syndrome, carpal tunnel syndrome and insomnia.

### **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, C5-C6, and C6-C7 x3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation AMA Guides

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

**Decision rationale:** The MTUS Chronic Pain Guidelines indicate "repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year." This patient has continued neck pain radiating into bilateral hands. She was treated with epidural steroid injections (ESIS) prior to the surgery. As per the records submitted there is no documentation indicating that a prior trial of injections had any functional improvement or 50% pain relief with associated reduction in medication use. Also it is unclear how many injections she had and response to the injections is unknown. Furthermore, the MTUS Chronic Pain Guidelines do not recommend more than 2 ESI injections in either the diagnostic or therapeutic phase. The request is for cervical epidural injection at C4-5, C5-6, and C6-7 x3, which exceeds the MTUS Chronic Pain Guidelines' recommendation. Therefore, the request for cervical epidural injections is not medically necessary and appropriate.