Case Number:	CM14-0001699		
Date Assigned:	07/02/2014	Date of Injury:	10/05/2012
Decision Date:	07/31/2014	UR Denial Date:	12/12/2013
Priority:	Standard	Application Received:	01/02/2014

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, and is licensed to practice in Illinois. 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 injured worker is a 35-year-old female with a reported date of injury on 10/05/2012. The injury reportedly occurred when the injured worker lifted a box from the floor and immediately felt a burning sensation in her spine from her neck down. The injured worker diagnoses were noted to include cervical radiculopathy with cervical disc bulges and annular tear at C3-4, acquired cervical torticolis and cervical dystonia, mild cervical scoliosis, asymmetric myospasm with myofascial trigger points, lumbar pain with myospasm and myofascial trigger points, and chronic pain secondary to injury. The injured worker previous treatments were noted to include physical therapy, cervical epidural steroid injections, and medications. The provider reported a cervical spine MRI (magnetic resonance imaging) on an unknown date noted at C3-4 there was a small posterior central disc bulge; however, this was associated with an annular tear. At C4-5, there was a mild central and left lateral disc/osteophyte complex partially affecting the thecal sac. At C5-6, there was moderate effacement of the thecal sac with a 2.5mm central and paracentral protrusion which resulted in central stenosis of the canal. At C6-7, there was a small left lateral disc osteophyte complex. The progress note dated 06/14/2014 reported the injured worker had a second epidural steroid injection performed on 02/23/2014 with a noted improved range of motion, but noted that she still had upper extremity pain that had not yet responded to the injections. The injured worker had an increased range of motion in her cervical spine with greater than 70% improvement, and was able to sleep better and move better. The injured worker continued to complain of cervical pain radiating into her bilateral lower extremities that was described as stabbing. The injured worker reported she had a great deal of temperature sensitivity in her neck and upper extremities and she was very sensitive to the cold as it triggers pain. The injured worker also noted that she had tightness and spasm in her muscles and her range of motion is the most improved that it had been; however, her pain and sensitivity to

temperature were still quite significant. The injured worker reported her overall pain had decreased since her last visit, and rated her pain as 3/10 and described it as shooting and burning. The physical examination of cervical spine revealed the injured worker sat with her head deviated in a forward flexion of 5 degrees. She was noted to have head forward position of 3 fingerbreadths, and a three of chin deviation to the left and head deviation, and her right shoulder sat 3.0cm lower than her left. The range of motion testing to the cervical spine was noted to be forward flexion was 45 degrees, extension was 50 degrees, right rotation was 45 degrees, left rotation was 45 degrees, and lateral flexion to the right was 15 degrees, and to the left was 15 degrees. There was pain with palpation over the bilateral trapezius musculature and the cervical paraspinous musculature. There was also tenderness of the levator scapulae and rhomboid musculature. There were several myofascial trigger points in the areas, left tenderness noted over the levator scapulae and rhomboid musculature. The neurological exam revealed reflexes were two plus, symmetrical and bilateral biceps, triceps, brachioradialis jerks. Motor strength testing was noted to be 5/5 and symmetric. Sensation was mildly decreased bilaterally from her neck to her shoulders. The Request for Authorization form was not submitted within the medical records. The request for cervical epidural steroid injection to C3, C4 and C5 is due to cervical radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

CESI C3, C4 and C5: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: The California MTUS recommend epidural steroid injection as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy.) Most current guidelines recommend no more than two epidural steroid injections. Research has not shown that, on average, less than 2 injections are required for successful epidural steroid injection outcome. The current recommendations suggest a second epidural injection if partial success is produced with the first injection, a third is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts including a continuing home exercise program. A study recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between two to six weeks following the injection but they do not affect impairment of function or the need for surgery and do not provide long term pain relief beyond three months and there is insufficient evidence of make any recommendation for the use of epidural steroid injection to treat radicular cervical pain. The riteria for the use of epidural steroid injections is radiculopathy and must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The guidelines also state the injured worker must be initially unresponsive to conservative treatment (exercises, physical methods and non-steroidal anti-inflammatory drugs (NSAIDs) and muscle relaxants.) The

guidelines also state injections should be performed using fluoroscopy and in the therapeutic phase, 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 6 to 8 weeks and with a general recommendation of no more than four blocks per region per year. In this case, the injured worker has had two previous cervical epidural steroid injections. The documentation provided reported the injured worker had improved range of motion but still had upper extremity pain from the second epidural steroid injection performed 02/23/2014. The injured worker had increased range of motion in her cervical spine with greater than 70% improvement and was able to sleep better and move better; however, it does not document the reduction in pain and, in fact, states that her upper extremity pain had not responded to the injections. Additionally, the provided reported the injured worker's motor strength was rated 5/5 and sensation was mildly decreased bilaterally from her neck to shoulders which is not a significant amount of clinical findings to warrant a cervical epidural steroid injection. Therefore, the request for cervical epidural steroid injection C3, C4 and C5 is non-certified.