

Case Number:	CM14-0003877		
Date Assigned:	01/31/2014	Date of Injury:	04/06/2008
Decision Date:	06/30/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/09/2014

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 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 is a 49-year-old female who has submitted a claim for bilateral cervical radiculopathy, displacement of cervical intervertebral disc without myelopathy associated with an industrial injury date of April 6, 2008. Medical records from 2013 were reviewed, the latest of which dated December 19, 2013 revealed that the patient continues to have symptoms in the neck and the shoulders. The right shoulder pain is improving slightly. She needs to take hydrocodone on a regular basis to control the pain. There is still pain in the neck and left shoulder. The pain seems to radiate from the side of the neck. She feels tingling in the region of pain when pain is severe. On physical examination, there is decreased range of motion to about 60% of normal due to pain. There is muscle tightness bilaterally in the neck, left paraspinal muscles more painful than the right. There is dysesthesia over the shoulder areas on palpation both sides. MRI of the cervical spine done last March 22, 2008 revealed C6-C7 disc spur on the left side with suspected protrusion. The CSF space is nearly effaced ventral to the cord. Neural canal on the left is narrowed as a suit of uncinat process hypertrophy and facet joint hypertrophy. C5-C6 shows uncinat process hypertrophy and facet joint hypertrophy narrowing the neural canal on the left. MRI of the cervical spine done last June 17, 2010 revealed intervertebral disc disease and degenerative changes of the cervical spine. There is mild straightening of the cervical lordosis, which can be seen with muscle spasm or neck pain. Mild grade 1 retrolisthesis of C5 on C6 and C6 on C7. Both measure approximately 5% or less of the AP diameter of their respective vertebral bodies. Mild canal stenosis at C6-7. The AP diameter of the thecal sac measures approximately 9mm. Moderate left sided neural foraminal narrowing at C6-7 with mild to moderate left sided neural foraminal narrowing at C5-6. Electrodiagnostic studies of the bilateral upper extremities done last June 22, 2010 revealed findings that are compatible with chronic cervical radiculopathy, superimposed with acute ongoing denervations

at the left C6-7 root levels. MRI of the cervical spine done last May 29, 2012 revealed mild to moderate degenerative changes is noted in the cervical spine, focally most prominent at the C4-C7 levels. Circumferential posterior bony osteophytic changes are present, most prominent at C4-5 and C6-7 levels, left greater than right. There is associated bony foraminal stenosis on the left most prominent at C5-6 and less at C6-7. MRI of the cervical spine done last December 9, 2013 revealed C4-5 broad left paracentral posterolateral 4mm disc protrusion causing moderate stenosis of the left lateral recess and contracting the anterior margin of the cervical cord, without central canal stenosis or cord compression. C5-6 and C6-7 discectomies with solid anterior fixation in normal alignment and with patent central canal. Mild left foraminal narrowing is present at both levels but no stenosis is suspected. Treatment to date has included cervical epidural steroid injection (5/21/09, 7/6/10, 3/14/12), trigger point injections (7/6/10), anterior decompression and fusion of the cervical spine (July 2012), physical therapy, home exercise program, and medications which include Soma, Vicodin, Arthrotec, hydrocodone and gabapentin. Utilization review from December 30 2013 denied the request for CERVICAL EPIDURAL STEROID INJECTIONS VIA THORACIC APPROACH QTY:1 because there is no neuroforaminal stenosis on MRI to support a cervical radiculopathy. There is also no significant neurologic sign on physical examination to support the diagnosis of cervical radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL EPIDURAL STEROID INJECTIONS VIA THORACIC APPROACH QTY:1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, EPIDURAL STEROID INJECTION, 46

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines 9792.24.2, Page(s): 46.

Decision rationale: According to page 46 of the CA MTUS Chronic Pain Medical Treatment Guidelines, criteria for epidural steroid injections include the following: radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing; initially unresponsive to conservative treatment; and no more than two nerve root levels should be injected using transforaminal blocks. In this case, cervical epidural steroid injection was requested as a diagnostic injection to see whether it can give the patient any relief from radicular pain. The purpose is to treat the pain so the patient can take less narcotics and improve her chance to stay at work. The patient has had several cervical epidural steroid injections, the latest given last March 14, 2012. The patient had a history of conservative treatment; however, there was no documented analgesia or functional improvement. Electrodiagnostic study and MRI results also support the diagnosis of cervical radiculopathy. In the most recent clinical evaluation, the patient still complains of neck pain associated with tingling sensation. On physical examination, there is decreased range of motion to about 60% of normal due to pain. There is muscle tightness bilaterally in the neck; left paraspinal muscles

more painful than the right. There are subjective and objective findings that warrant further treatment with epidural steroid injections. However, the nerve root level/s was not specified in the request. Therefore, the request for CERVICAL EPIDURAL STEROID INJECTIONS VIA THORACIC APPROACH to an unspecified nerve root level is not medically necessary.