

<b>Case Number:</b>	CM14-0007170		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	12/04/2012
<b>Decision Date:</b>	07/17/2014	<b>UR Denial Date:</b>	01/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/20/2014

### 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 52-year-old male who has submitted a claim for cervical radiculopathy, cervical disc degeneration, lumbar radiculopathy, lumbar disc degeneration, hypertension, and GERD associated with an industrial injury date of December 4, 2012. The Medical records from 2013 to 2014 were reviewed. The Patient complained of cervical pain radiating to bilateral upper extremities to the level of the hand and fingers, associated with tingling and numbness sensation. The Average pain scale was 6/10 with medications, and 9/10 without medications. The Physical examination of the cervical spine revealed muscle spasm, tenderness and moderate reduction in motion secondary to pain. Grip strength testing with Jamar hand dynamometer showed right (40-60-80), and left (60-90-70). Motor testing revealed decreased strength at bilateral upper extremities. Hyperreflexia was noted at bilateral biceps, right more than left. Sensation was diminished at bilateral C4 to C5 dermatomes. The MRI of the cervical spine, dated June 5, 2013, revealed that at C3 to C4, there was a left paracentral 3mm distal protrusion indenting the anterior spinal cord resulting in mild canal stenosis and severe left neural foraminal narrowing with impingement of exiting left C4 nerve root. At C4 to C5 and C5 to C6, there were mild bilateral facet arthropathy and right paracentral uncovertebral hypertrophy resulting in mild right neural foraminal narrowing. Treatment to date has included lumbar epidural steroid injection, home exercise program, physical therapy, activity modifications, and medications. Utilization review from January 7, 2014 did not grant the request for cervical epidural injection at bilateral C3 to C5 because progress report did not show any sensory or motor changes in a radicular distribution.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CERVICAL EPIDURAL BILATERAL C3-C5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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

**Decision rationale:** As stated on page 46 of the California MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. The Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, the documented rationale for performing a cervical ESI is because patient had failed drug therapy, activity modifications and physical therapy. The Goals of ESI are to decrease pain and inflammation, to restore range of motion, and to avoid surgery. The Patient complained of cervical pain radiating to bilateral upper extremities to the level of hand and fingers, associated with tingling and numbness sensation. On physical examination, weakness, dysesthesia, and hyperreflexia were noted. Manifestations are consistent with radiculopathy. The MRI of the cervical spine, dated June 5, 2013, revealed that at C3-C4, there was severe left neural foraminal narrowing with impingement of exiting left C4 nerve root. At C4 to C5 and C5 to C6, there were mild bilateral facet arthropathy and right paracentral uncovertebral hypertrophy resulting in mild right neural foraminal narrowing. The medical necessity for performing ESI at C3-C4 level has been established; however, the MRI result at C4-C5 level only mentioned a mild form of neural foraminal narrowing. The Guideline criteria were not met. Therefore, the request for cervical epidural bilateral c3-c5 is not medically necessary.