

<b>Case Number:</b>	CM14-0007733		
<b>Date Assigned:</b>	02/10/2014	<b>Date of Injury:</b>	04/25/2012
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	12/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/16/2014

### 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 71-year-old female who has submitted a claim for cervical radiculopathy, cervical spondylosis, cervical degenerative disc disease, cervical sprain and strain, unsteady gait, and dizziness associated with an industrial injury date of April 25, 2012. Medical records from 2013 were reviewed. The patient complained of neck and medial trapezial area pain, grade 6/10 in severity. The pain radiates to the head, left shoulder, both upper extremities, and the coccyx. There was associated headache and dizziness from the pain and was aggravated by prolonged neck positioning and lifting. Physical examination showed tenderness over the cervical paraspinals, upper trapezius, and levator scapulae. There was decreased sensation to light touch on bilateral C7. There was also limited range of motion of the cervical spine. MRI of the of the cervical spine dated October 11, 2013 revealed broad-based spur-disc complex with bilateral uncovertebral joint hypertrophy at C6-C7 effacing the anterior subarachnoid space without cord compression or central canal stenosis, and severe bilateral neural foraminal narrowing with impingement of bilateral C7 exiting nerve roots. Treatment to date has included medications, physical therapy, chiropractic therapy, acupuncture, home exercise program, and activity modification. Utilization review, dated December 24, 2013, denied the request for epidural steroid injection for the cervical spine at bilateral C7 because the findings of radiculopathy were somewhat equivocal, as only decreased sensation bilaterally in the C7 dermatome was listed. The previous electrodiagnostic study did not show any cervical radiculopathy as well.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EPIDURAL STEROID INJECTION FOR THE CERVICAL SPINE AT BILATERAL C7:**  
Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** The 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. MTUS Guidelines do not support epidural injections in the absence of objective radiculopathy. In addition, MTUS criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology; and conservative treatment. Repeat blocks should only be offered if there is at least 50-70% pain relief for six to eight weeks following previous injection. In this case, a progress report dated November 22, 2013 states that cervical epidural steroid injection was requested for the treatment of cervical radicular pain concurrent with MRI findings and failing conservative management of physical therapy, home exercise program, medications, and relative rest. The patient manifested with focal neurologic deficit, specifically the objective evidence of decreased light touch sensation on bilateral C7 distribution. MRI done last October 11, 2013 showed severe bilateral neural foraminal narrowing with impingement of bilateral C7 exiting nerve roots. The MRI findings are consistent with the patient's physical examination. The patient still has persistent symptoms despite undergoing conservative treatment. The MTUS guideline criteria have been met. Therefore, the request for epidural steroid injection for the cervical spine at bilateral C7 is medically necessary.