

<b>Case Number:</b>	CM14-0125516		
<b>Date Assigned:</b>	08/11/2014	<b>Date of Injury:</b>	12/12/2005
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	07/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/07/2014

### 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 Anesthesia, has a subspecialty in Acupuncture and Pain 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:

58 year old female injured worker with date of injury 12/12/05 with related neck pain. Per progress note dated 6/10/14, she reported radiating pain into both arms with dysesthesias into both hands, worse with overhead activities. She stated that she had a previous cervical epidural steroid injection for her cervical degenerative disc disease and dysesthesias in her arm. She stated that that had helped her and she was literally pain-free for almost three years and would like to have a repeat steroid injection into her neck. Per physical exam, bilateral trapezial and parascapular trigger points in both upper extremities were noted. There were mild dysesthesias of both hands in the C5-6 nerve root distribution with associated numbness. An MRI of the cervical spine revealed degenerative disc changes at C5-6 and C6-7 with lesser changes at C7-T1. An EMG of the bilateral upper extremities dated 9/21/06 revealed evidence of moderate compression neuropathy of the median nerves across the bilateral wrists. No evidence of polyneuropathy or ongoing cervical radiculopathy, ongoing axon loss and ulnar neuropathy was noted. Treatment to date has included injections, chiropractic manipulation, and medication management.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical C7-T1 interlaminar epidural steroid injection:** Upheld

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

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

**Decision rationale:** Per the MTUS Chronic Pain Medical Treatment Guideline, epidural steroid injections are used to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs and avoiding surgery, but this treatment alone offers no significant long-term benefit. The criteria for the use of epidural steroid injections are as follows; radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants), injections should be performed using fluoroscopy (live x-ray) for guidance, if used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections, no more than two nerve root levels should be injected using transforaminal blocks, no more than one interlaminar level should be injected at one session, 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 six to eight weeks, with a general recommendation of no more than 4 blocks per region per year (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) and current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The imaging study and EMG in the documentation submitted for review do not corroborate findings.