

<b>Case Number:</b>	CM14-0153335		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	08/20/2007
<b>Decision Date:</b>	10/27/2014	<b>UR Denial Date:</b>	08/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2014

### 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 and 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 52-year-old female who reported injury on 08/20/2007. The mechanism of injury was the injured worker turned a box upside down and sustained injury. The surgical history included two shoulder surgeries. The documentation indicated the injured worker previously underwent a lumbar epidural steroid injection. The medications were not provided. The diagnostic studies included an x-ray of the thoracic spine and bilateral shoulders. The injured worker underwent an x-ray of the cervical spine in lateral, flexion, extension, and bilateral oblique as well as AP and odontoid views which revealed some loss of lordosis. The odontoid process was intact. There was no evidence of foraminal encroachment on the oblique view. The injured worker underwent an x-ray of the lumbosacral spine and pelvis. The injured worker's prior epidural steroid injection of the lumbar spine was dated 08/26/2010 and 09/02/2010. The injured worker underwent an MRI of the lumbosacral spine and right shoulder. The injured worker underwent an MRI of the cervical spine on 11/30/2013 which revealed at the level of C5-6, there was disc desiccation. There was mild loss of posterior intervertebral disc height. There was anterior disc protrusion and an endplate osteophyte complex. There was a 3 mm left paracentral posterior disc protrusion with endplate osteophyte complex with a central and right paracentral extension indenting the thecal sac and slightly impinging on the left anterior spinal cord. There was mild to moderate central canal stenosis. There was mild left neural foraminal stenosis. At the level of C6-7, there was no disc desiccation. There was some mild loss of posterior intervertebral disc height. There was a 2 mm central posterior disc protrusion endplate osteophyte complex with bilateral paracentral extension indenting the thecal sac. There was mild hypertrophy at the ligamentum flavum indenting the posterior thecal sac. There was mild central canal stenosis. The most recent documentation was dated 08/28/2014 which revealed the injured worker had complaints of constant neck pain radiating into her right upper

extremity causing weakness upon grip. The injured worker had bilateral shoulder pain and low back pain. The injured worker had a positive cervical compression test, a positive Jackson's test and Romberg's test on the right. The Romberg's test was greater on the right than left. The injured worker had a positive Adson's. There was loss of sensation in the C6 nerve distribution on the right. The diagnosis included 4 mm disc bulge C4-5 and C5-6 per MRI. The injured worker was status post arthroscopic repair right shoulder 2 times. The discussion included the examiner was of the opinion the injured worker's bilateral shoulder pain resulted from discogenic injury within the cervical spine rather than right shoulder and left shoulder pain. The documentation of 08/06/2014 revealed the injured worker had complaints of persistent pain in the neck, worse when lifting, pulling and pushing. The pain radiated into the mid back and both arms. There was numbness in the right arm and weakness in the bilateral arms. The physical examination of the cervical spine revealed normal cervical lordosis. There was tenderness to palpation in the bilateral trapezii. There was decreased range of motion with neck pain and arm pain in cervical extension, bilateral flexion and bilateral rotation. The injured worker's strength was within normal limits. Light touch sensation was intact to both upper extremities. The office note provided revealed page 1 through 5 of 8 pages and pages 6 through 8 were not provided, which included the objective findings, treatment plan and diagnoses. There was no request for authorization submitted for review. There was no rationale submitted for the cervical epidural steroid injection.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Cervical Epidural Steroidal Injection under Fluoroscopy C5-C6, C6-C7, quantity: 2:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Epidural steroid injections Page(s): 46.

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

**Decision rationale:** The California MTUS Guidelines recommend epidural steroid injections when there is documentation of radiculopathy upon physical examination that is corroborated by imaging and/or electrodiagnostic testing. There should be documentation of a failure of conservative care including physical medicine, NSAIDs and muscle relaxants. The clinical documentation submitted for review failed to provide documentation of the above criteria. The MRI indicated the injured worker had mild to moderate canal stenosis at C5-6. However, there was a lack of documentation indicating the injured worker had nerve impingement at C5-6 and C6-7. There was a lack of documentation of a failure of conservative care specifically for the cervical spine. The physician documentation indicated the injured worker had objective findings at the level of C6. Given the above, the request for cervical epidural steroid injection under fluoroscopy C5-6, C6-7, quantity 2 is not medically necessary. Additionally, there was a lack of clarification indicating if the request was for a series of 2 injections or whether the request was for the 2 levels of injection. Given the above and the lack of documentation, the request for

cervical epidural steroid injection under fluoroscopy C5-6, C6-7, quantity 2 is not medically necessary.