

<b>Case Number:</b>	CM14-0174411		
<b>Date Assigned:</b>	10/27/2014	<b>Date of Injury:</b>	06/13/2005
<b>Decision Date:</b>	12/03/2014	<b>UR Denial Date:</b>	09/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2014

### 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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 65-year-old woman who sustained a work-related injury June 13, 2005. Subsequently, she developed chronic neck and low back pain. MRI of the cervical spine dated June 22, 2010 documented cervical disc disease, moderate at C3-4, mild to slight at C4-5, and slight at C6-7. EMG/NCV study performed on February 22, 2012, documented electrodiagnostic evidence of low-grade bilateral C5 cervical radiculopathy pattern, more prominent on the right side, with chronic and denervation components. Electrodiagnostic evidence of mild bilateral sensory only median nerve entrapment at the wrists without motor involvement. The patient had 4 cervical epidural steroid injections in 2007, one in August 2012 and again on April 2013 with more than 50% improvement. The patient also had had shock wave on low back, which had helped her. A progress report dated August 14, 2014 indicated that the patient had pain rated as 4-5/10. On physical examination, the cervical spine motion was flexion 90 degrees, extension 40 degrees, right lateral bending 25 degrees, and left lateral bending 30 degrees. The right shoulder abduction power was normal. The right wrist extensor power was normal, and right wrist flexor power was normal. The right finger flexor power was normal. Light touch sensation was intact in the right lateral shoulder, the tip of the right thumb, the tip of the right long finger, and the tip of the right small finger. The right shoulder rotation was 60 degrees and left shoulder rotation was 60 degrees. Treatment plan called for chiropractic care and medications. According to the progress report dated September 9, 2014, the patient complained of pain in the neck, upper and lower back, bilateral shoulders, and bilateral wrists. The patient stated that chiropractic treatment and shockwave have helped to manage the pain and increase mobility and functionality. The patient was diagnosed with cervical spine disc bulge, thoracic spine strain, lumbar spine strain, right shoulder strain, left shoulder strain, right wrist/hand strain, and left wrist/hand strain. The

patient underwent cervical epidural injection on August 2012 with 50% improvement of the pain. The provider requested authorization for cervical epidural steroid injections.

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

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

**Cervical Epidural Injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

**Decision rationale:** According to MTUS guidelines, cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. Epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit, however there is no significant long term benefit or reduction for the need of surgery. Furthermore, the patient file does not document that the patient is candidate for surgery. In addition, there is no clinical and objective documentation of radiculopathy. MTUS guidelines does not recommend epidural injections for neck pain without radiculopathy. There is no documentation of the duration of improvement of previous epidural injection. Therefore, the request for cervical epidural steroid injections is not medically necessary.