

<b>Case Number:</b>	CM14-0180315		
<b>Date Assigned:</b>	11/04/2014	<b>Date of Injury:</b>	05/31/2012
<b>Decision Date:</b>	12/10/2014	<b>UR Denial Date:</b>	10/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2014

### 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 51-year-old woman who sustained a work-related injury on May 31, 2012. Subsequently, she developed chronic neck pain. MRI of the cervical spine done on April 28, 2014 showed a reversal of the cervical lordosis; at C3-4: there is a 3mm midline disc protrusion resulting in abutment of the cervical cord with a moderate degree of central canal narrowing; at C5-6 and C6-7 there are 3 mm midline disc protrusions resulting in mid-to-moderate central canal narrowing; at C5-6 there is a right foraminal disc protrusion with abutment of the existing right cervical nerve root. The EMG/NCV studies performed on June 9, 2014 documented no electrical evidence of bilateral cubital or carpal tunnel syndrome; no electrical evidence of a cervical radiculopathy or brachial plexopathy affecting the C5 through T1 lower motor nerve fibers of the bilateral upper extremities or the cervical paraspinals; no electrical evidence of a generalized peripheral neuropathy. A report dated October 16, 2014 documented that in the progress report dated September 30, 2014, the patient complained of neck pain rated at 5/10. The pain was described as non-radiating achy, stiffness, and soreness. The patient reported decreased neck pain due to one injection to the right C5-6, transfacet epidural steroid injection on August 18, 2014. The patient had 50-60% relief of pain and improved range of motion. Her cervical examination revealed tenderness with spasm in the cervical paraspinal musculature and the bilateral trapezii muscles. Axial head compression test was positive on the right, Spurling's test was positive on the right, and there was facet tenderness at C6-7. Sensation to pinprick and light touch was diminished along the right C6-7 dermatomes. C5 muscle strength testing was 4/5 and the brachioradialis reflex was 1+. The patient was diagnosed with cervical disc disease, cervical radiculopathy, cervical facet syndrome, bilateral shoulder impingement, status post bilateral carpal tunnel release, and status post bilateral de Quervain's release. The provider requested authorization for a second right C5-6 and C6-7 transfacet ESI and UDS.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Second right C5-6 and C6-7 Transfacet Epidural Steroid Injection:** Upheld

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

**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, the EMG/NCV study showed the absence of radiculopathy. MTUS guidelines does not recommend epidural injections for neck pain without radiculopathy. In additon there is no clear documentation of functional improvement with previous cervical epidural injection. Therefore, the request for second right C5-C6 and C6-C7 transfacet epidural steroid injection is not medically necessary.

### **Urine Toxicology Screening:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Urine Drug Testing (UDT)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction Page(s): 77-78; 94.

**Decision rationale:** According to MTUS guidelines, urine toxicology screens is indicated to avoid misuse/addiction. <(j) Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs>.There is no evidence that the patient have aberrent behaviour or urine drug screen. There is no clear evidence of abuse, addiction and poor pain control. There is no documentation that the patient have a history of use of illicit drugs. Therefore, the request for Urine drug screen is not medically necessary.