

<b>Case Number:</b>	CM14-0023651		
<b>Date Assigned:</b>	06/18/2014	<b>Date of Injury:</b>	01/01/1988
<b>Decision Date:</b>	07/21/2014	<b>UR Denial Date:</b>	02/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2014

### 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 Internal 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:

Patient is an injured worker status post cervical spine surgery. Date of injury was 01-01-1988. Progress note 01-02-2014 by treating physician ██████ documented subjective complaints of neck and upper extremity pain. Objective findings: Tender in the lower cervical spine. Range of motion is decreased in all fields. Reflexes of upper extremities are 2+. Strength is decreased to 4/5 bilaterally and the maneuvers caused pain. Diagnoses: multiple neck surgeries, 4-level fusion with anterior and posterior instrumentation; chronic right shoulder pain, right shoulder surgery in 1997; EMG/NCV studies from 05/14/2013 showed mild bilateral carpal tunnel syndrome, left ulnar neuropathy across the elbow. Requested procedure: repeat the T1/2 ESI that was done on 9/18/13. Cervical Spine Magnetic Resonance Imaging was performed July 15, 2013. Osseous Structures: Again noted is extensive surgery involving the cervical spine with postsurgical changes with solid bony fusion both anteriorly and posteriorly seen involving C3, C4, C5, C6, and C7. There is associated straightening of the normal cervical lordosis and Minimal anterolisthesis at the C7-T1 level. Degenerative changes are seen involving the left C2-C3 apophyseal joint. Spinal Cord and Canal: The cervical spinal cord is within normal limits for size and signal intensity. No intramedullary or extra medullary masses are seen. No bony stenosis of the spinal canal is identified. There is mild to moderate narrowing of the left C3 neural foramen. The remainder of the visualized neural foramina are within normal limits.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**INJECTION FORAMEN EPIDURAL C/T: 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): 175, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** Medical treatment utilization schedule (MTUS) Chronic Pain Medical Treatment Guidelines (Page 46) states that Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The American Academy of Neurology recently concluded that there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. ESI treatment alone offers no significant long-term functional benefit. Criteria for the use of Epidural steroid injections: Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. An MRI of cervical spine 07-15-2013 reported that the C7-T1 disk was of normal size, configuration, and signal intensity with no evidence of a protrusion or bulge. Mild anterolisthesis was noted at the C7-T1 level without significant spinal stenosis or foraminal narrowing identified. Progress note 01-02-2014 by treating physician [REDACTED] documented that EMG/NCV studies from 05/14/2013 showed mild bilateral carpal tunnel syndrome, left ulnar neuropathy across the elbow. MRI and EMG/NCV studies do not corroborate radiculopathy. Per MTUS and ACOEM guidelines, medical records do not support the medical necessity of epidural steroid injections.