

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0031787 | | |
| Date Assigned: | 03/26/2014 | Date of Injury: | 06/03/2011 |
| Decision Date: | 05/07/2014 | UR Denial Date: | 02/19/2014 |
| Priority: | Standard | Application Received: | 03/14/2014 |

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 & Rehabilitation and is licensed to practice in Maryland. 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 63 year old female who sustained a work injury when she was hit in the head with a basketball on 6/3/11. She has a diagnoses of cervicalgia and cervical radiculopathy. Treatment has included physical therapy, medication management, facet injections, acupuncture. There is a request for a C5-6 transforaminal epidural steroid injection. This was denied on prior utilization review dated 2/19/14 with reason cited that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In addition, no more than two nerve root levels should be injected using transforaminal blocks, and no more than one interlaminar level should be injected at one session. The reviewer stated that there is no evidence of frank nerve root compromise on MRI. There is a document dated 1/24/14 which states that the patient has RUE pain with numbness to the thumb and a positive Spurling. The patient has good strength in the BUE. An EMG of bilateral upper extremities 10/22/13 electrodiagnostic study reveals: Needle evaluation of the right low cervical paraspinal, the right deltoid, and the right infraspinatus muscles showed increased insertional activity, slightly increased spontaneous activity, slightly increased polyphasic potentials, and diminished recruitment. The right supraspinatus, the right biceps, the right abductor pollicis brevis, the right first dorsal interosseous, and the left triceps muscles showed slightly increased spontaneous activity. The left low cervical paraspinal muscle showed increased insertional activity, slightly increased spontaneous activity, and diminished recruitment. The left biceps muscle showed slightly increased polyphasic potentials. All remaining muscles (as indicated in the following table) showed no evidence of electrical instability. The impression on the report reads: "This is an abnormal electrodiagnostic study (EMG/NCS) of bilateral upper extremities. 2. No polyneuropathy, No myopathy. 3. Right Moderate Carpal Tunnel Syndrome 4. Left Mild Carpal Tunnel Syndrome 5. Bilateral Ulnar sensory mononeuropathy 6. Bilateral C5 Cervical

Radiculopathy." A Cervical MRI dated 9/3/11 revealed there is symmetric severe facet hypertrophy on the right at C3-4 and C4-5 contributing to asymmetric right sided foraminal stenosis. Tiny 1 mm central disc protrusions at C2-3, C3-4 and C4-5 are causing trace central stenosis. Another Cervical MRI dated 9/17/13 reveals there is a new 2 cm central disc protrusion at C5-6 causing mild central canal stenosis and the remainder of the exam is unchanged from prior study. A 2/14/12 operative report indicates that the patient had a left C3 facet nerve block, left C4 cervical facet nerve block, left C5 and C6 cervical facet nerve block. There is an additional operative report dated 10/25/11 that indicates that the patient had an epidural injection at T1-T2 on 0/25/11.

IMR ISSUES, DECISIONS AND RATIONALES

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

C5-6 TRANSFORAMINAL EPIDURAL STEROID INJECTION: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

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

Decision rationale: The MTUS Chronic Pain Guidelines' criteria for epidural steroid injections state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing and that the patient is initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants. The documentation indicates that the patient has had conservative management but still has symptoms. The documentation submitted and reviewed indicates that there are clinical findings suggestive of a right C6 radiculopathy. The radiculopathy is documented by physical examination and corroborated by both patient's MRI and electrodiagnostic testing. In reviewing the documentation it appears that the denervation on muscles on the right arm tested on needle portion of the electrodiagnostic testing are more suggestive of a right C6 radiculopathy (rather than a C5) . This correlates with patient's radicular symptoms to the thumb as well as the MRI findings of a new central disc protrusion at C5-6. In reviewing the muscles tested on EMG it is evident that there is innervation by the C6 nerve roots as well to these muscles. Without evaluating the rhomboid (C5) muscles and pronator teres (C6, 7) muscle in this case it is difficult to discern a C5 from a C6 radiculopathy. Given the abnormal needle findings in the muscles affected (innervated by both C5 and C6) and the patient's clinical history of a positive Spurling with radiating symptoms to the right thumb, as well as a new disc protrusion at C5-6, the findings are actually more suggestive of a right C6 radiculopathy. The documentation also indicates patient has had a prior epidural steroid injection in the thoracic spine and therefore the response to this injection would not adequately assess whether the current injection will be beneficial or not. The request is medically necessary and appropriate.