

Case Number:	CM14-0058914		
Date Assigned:	07/09/2014	Date of Injury:	05/01/2007
Decision Date:	09/05/2014	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	04/29/2014

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 Occupational 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:

The 55 year old right-handed female secretary injured from cumulative trauma over the time period of 1 May 2006 to 1 May 2007 (judged to be 60% from non-industrial cause and 40% from industrial cause) which triggered neck pain, bilateral shoulder pain, bilateral elbow pain and bilateral wrist pain with numbness and tingling in a median nerve (C5-6) distribution, and occasional occipital headaches. Pain is causing difficulty sleeping. In Feb 2012, this pain was listed as 10/10, made worse with all neck motion and associated with difficulty grasping items and performing fine manipulation resulting in difficulty performing activities of daily living (e.g. cooking and cleaning). Co-morbid medical conditions include insulin-dependent diabetes (47 years) and peripheral neuropathy in the lower extremities. Exam in Feb 2012 revealed limited range of motion with tenderness over spinous processes in the neck with paravertebral muscle hyper tonicity and a positive Spurling's maneuver. In Jan 2014 examination was very similar. In Feb and Mar of 2011, she had nerve studies that showed polyneuropathy and bilateral carpal tunnel syndrome. A repeat nerve study in Oct 2013 was consistent with moderate left and mild right Carpal Tunnel Syndrome. An MRI of both shoulders in Sep 2011 revealed changes consistent with chronic rotator cuff tendonitis. An MRI of cervical spine without contrast performed on 29 Sep 2011 revealed degenerative changes from C3-C5 with reversal of curvature but without foraminal narrowing at any level; a posterior central disc protrusion at C4-5 which contacts the spinal cord but does not deform or displace it; a posterior central and right paracentral disc protrusion at C5-6 which contacts the spinal cord but does not deform or displace it. She has been treated with Right Carpal Tunnel release, physical therapy, and acupuncture, steroid injection in right shoulder and left elbow, and medical management (Tylenol No3, Tramadol, Vicodin 5 mg, Over-the-Counter Tylenol, Vitamin B6) without

resolution of pain. In Feb 2012, an epidural steroid injection was recommended but no records indicate this was ever accomplished.

IMR ISSUES, DECISIONS AND RATIONALES

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

C5-6 Cervical epidural Injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175, 181-2.

Decision rationale: Epidural steroid injections are an optional treatment for pain caused by nerve root inflammation, that is, pain in a specific dermatome pattern consistent with physical findings attributed to the same nerve root. The ACOEM guidelines point out its use has uncertain benefits in neck pathology other than as a non-surgical treatment for nerve root compromise to clarify nerve root dysfunction prior to surgery. As per the MTUS the effects of epidural steroid injections usually will offer the patient only short term relief of symptoms as they do not usually provide relief past 3 months, so other treatment modalities are required to rehabilitate the patient's functional capacity. If these other treatment modalities have already been tried and failed, use of epidural steroid injection treatment becomes questionable; unless surgery on the neck is, being considered which in this case there is no documentation that that is so. The MTUS also provides very specific criteria for use of this therapy. Specifically, the presence of a radiculopathy documented by examination, corroborated by imaging, and evidence that the patient is unresponsive to conservative treatment. For this patient there is no documentation on examination of the radicular nature for the patient's symptoms. The pattern seen in this patient that the providers are calling "radicular" is better attributed to her bilateral carpal tunnel syndrome and her diabetic polyneuropathy. The MRI also does not show nerve root compression. The records do show poor or inadequate response to physical therapy, acupuncture and use of some medications (pain medications and vitamin B6) but no evidence of use of non-steroidal anti-inflammatory medications (NSAIDs) or muscle relaxants. At this time, there are no good indications for use of epidural steroids in the treatment of this patient. Therefore, the request is not medically necessary.