

Case Number:	CM14-0015746		
Date Assigned:	06/04/2014	Date of Injury:	01/09/2013
Decision Date:	09/28/2015	UR Denial Date:	01/29/2014
Priority:	Standard	Application Received:	02/07/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 56-year-old male with a January 9, 2013 date of injury. A progress note dated November 11, 2013 documents subjective complaints (ongoing neck pain radiating to the shoulders and upper extremities; weakness in the hands; bilateral upper extremity pain; pain rated at a level of 7 out of 10; bilateral hand numbness and tingling, right greater than left; constant numbness and tingling in the bilateral third, fourth, and fifth digits), objective findings (tenderness to palpation of the cervical spine; decreased range of motion of the cervical spine; decreased sensation in the left C5, C6, and C7 dermatomes; decreased strength of the bilateral deltoids, biceps, internal and external rotators, and left wrist extensors; positive Tinel's and Phalen's bilaterally; decreased range of motion of the bilateral wrists), and current diagnoses (herniated nucleus pulposus of the cervical spine; cervical radiculopathy; moderate to severe disc space narrowing at C5-C6; bilateral wrist hand carpal tunnel syndrome). Treatments to date have included medications, electromyogram of the right upper extremity (August 21, 2013; showed evidence of right median neuropathy at the wrist), electromyogram of the left upper extremity (February 21, 2013; showed left cervical radiculopathy and left carpal tunnel syndrome), magnetic resonance imaging of the cervical spine (February 15, 2013; showed cervicothoracic spondylosis, straightening of cervical lordosis, multilevel posterior bulging discs and osteophytes, and stenosis), chiropractic treatments, and physical therapy. The medical record indicates that medications help control the pain. The treating physician documented a plan of care that included an interlaminar epidural steroid injection at C5-C6.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interlaminar Epidural Steroid Injection at C5-C6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESI's) Page(s): 46.

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

Decision rationale: The patient presents on 09/16/13 with neck pain, which radiates into the bilateral upper extremities. The patient's date of injury is 01/09/13. Patient has no documented surgical history directed at this complaint. The request is for INTERLAMINAR EPIDURAL STEROID INJECTION AT C5-C6. The RFA is date 09/16/13. Physical examination dated 09/16/13 reveals reduced cervical range of motion in all planes, with no evidence of tenderness in the cervical region, and positive Phalen's sign, Tinel's sign, and compression tests noted in the bilateral wrists. The patient is currently prescribed Omeprazole, Hydrocodone, Naproxen, and Terocin patches. Electro diagnostic study of the upper extremities, dated 08/23/13 was provided, significant findings include: "... evidence of right medial neuropathy at the wrist... this is consistent with moderate to severe carpal tunnel syndrome... There is no electro diagnostic evidence of cervical radiculopathy or generalized peripheral neuropathy affecting the right upper limb..." Discussion of a cervical MRI dated 02/15/13 was also included, stating: "C5-c6, mild to moderate canal with possible left compression of cord, but no myelopathy. C6-7 mild canal stenosis, but no cord compression or myelopathy. Multilevel foraminal stenosis, severe, moderate to severe at several levels..." Per 09/16/13 progress note, patient is currently classified as temporarily partially disabled through 11/01/13. MTUS Guidelines, Epidural Steroid Injections section, page 46: "Criteria for the use of Epidural steroid injections: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. 3. Injections should be performed using fluoroscopy (live x-ray) for guidance. 8) Current research does not support "series-of-three" injections in either the diagnostic or the therapeutic phase. We recommend no more than 2 ESI injections." In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. MTUS Guidelines, Epidural Steroid Injections section, page 46 clearly states: "there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain." In this case, the treater is requesting an initial cervical ESI targeted at the C5-6 level. Progress note dated 09/16/15 provides subjective reports of radicular pain, however the physical examination findings to not clarify whether the pain in the upper extremities originates in the cervical spine. Prior examinations, however, do note some decreased sensation in the upper extremities along specific dermatomal distributions, but it is not clear why these findings are not repeated or present in the most recent examination. This patient's MRI dated 02/15/13 does have some findings of foraminal narrowing in the cervical spine. Conflicting with these findings, an upper extremity NCV/EMG dated 02/21/13 includes evidence of carpal tunnel syndrome; however, the remaining electro diagnostic findings are not suggestive of

cervical radiculopathy. While this patient presents with significant pain complaints unresolved by other interventions, the documentation provided does not clearly indicate that this patient's upper extremity complaints are cervical in origin. Furthermore, MTUS guidelines also state that there is insufficient evidence of the efficacy of cervical ESI to treat cervical radicular pain. Given the lack of unequivocal examination findings indicative of cervical radiculopathy in the most recent progress note, the conflicting electro diagnostic and magnetic resonance results, and the lack of firm guideline support for cervical ESI's directed at radicular pain, the request cannot be substantiated. Therefore, the request IS NOT medically necessary.