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| Case Number: | CM14-0120301 | | |
| Date Assigned: | 08/06/2014 | Date of Injury: | 05/13/1991 |
| Decision Date: | 02/04/2015 | UR Denial Date: | 07/18/2014 |
| Priority: | Standard | Application Received: | 07/30/2014 |

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 66-year-old man who sustained a work-related injury on March 13, 1991. Subsequently, the patient developed neck and low back pain. EMG study performed on March 29, 2010 documented a right C5 and C6 radiculopathy as well as a bilateral lower extremity L5 and S1 radiculopathy. However, EMG study performed on August 28, 2006 did not reveal any radiculopathy in the lower extremities. Lumbar spine MRI performed on December 5, 2007 revealed post surgical changes, with moderate to severe central stenosis at L3-4 secondary to facet arthropathy and ligamentum flavum hypertrophy. There was mild to moderate central stenosis at L2-3. On a progress report dated July 3, 2014, the patient reported experiencing increased pain in his neck with associated cervicogenic headaches, as well as pain radiating down to both upper extremities. The patient rated his level of pain as an 8/10. The patient does have multilevel disc disease in his cervical spine and he is not interested in surgical intervention. The patient did undergo a cervical epidural steroid injection done on July 25, 2013, which provided close to 5 months of relief with notable improvement in mobility. The patient also complained of pain in his lower back, which radiates down to his lower extremities. The patient remained on his current oral analgesic medications, which include Norco, Motrin, and Lyrica but he still experience significant muscle rigidity/myospasms across his neck and lower back. Examination of the posterior cervical musculature revealed tenderness to palpation bilaterally with increased muscle rigidity. There were numerous trigger points that were palpable and tender throughout the cervical paraspinal muscles. The cervical spine and the shoulders range of motion were restricted by pain. Deep tendon reflexes were 2+ bilaterally. Upper extremity motor testing was 5/5 except for shoulder abductors right 4+/5 and elbow flexor and extensors 5-/5. Sensory examination to Wartenberg pinprick wheel was decreased along the lateral arm and forearm bilaterally at approximately the C5-6 distribution. Examination of the lumbar spine revealed

tenderness to palpation bilaterally with increased muscle rigidity. There were numerous trigger points that were palpable throughout the lumbar paraspinal muscles. Lumbar spine range of motion was restricted by pain. Deep tendon reflexes: Patellae 2/4 bilaterally and Achilles tendon bilaterally. Lower extremity motor testing was 5-/5 bilaterally. Sensory examination to Wartenburg pinprick wheel was decreased along the posterior lateral thigh and posterior lateral calf bilaterally in approximately the L5-S2 distribution. The straight leg raise was positive in the modified sitting position at 60 degrees bilaterally causing radicular symptoms. The patient was diagnosed with lumbar post-laminectomy syndrome, bilateral lower extremity radiculopathy with left greater than right, bilateral knee internal derangement, status post L4-5 and L5-S1 anterior interbody fusion done on July 11, 2002 status post left total knee replacement, status post right knee arthroscopic repair, cervical myoligamentous injury, right shoulder rotator cuff tear, and unsuccessful spinal cord stimulation trial. The provider requested authorization for cervical epidural steroid injection midline C5-6.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical epidural steroid injection midline C5-6: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, 309.

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, there is no documentation of functional and pain improvement with previous epidural steroid injection. MTUS guidelines does not recommend repeat epidural injections for neck pain without documentation of previous efficacy. There is no documentation of radiculopathy at C5-6, the requested level of injection. Therefore, the request for Cervical Epidural Steroid Injection midline C5-C6 is not medically necessary.