

<b>Case Number:</b>	CM14-0200511		
<b>Date Assigned:</b>	12/10/2014	<b>Date of Injury:</b>	04/17/2011
<b>Decision Date:</b>	01/28/2015	<b>UR Denial Date:</b>	11/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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 Anesthesiology, has a subspecialty in Pain Management, and is licensed to practice in Georgia. 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 54-year-old female presenting with a work-related injury on April 17, 2011. On October 27, 2014 the patient complained of left cervical and left upper limb pain. The pain was described as dull, throbbing, discomfort extending across the superior trapezius into the lateral arm to the elbow. The patient has a history of carpal tunnel syndrome confirmed by EMG with tingling, numbness into the first three digit of both hands. According to the medical records the patient underwent physical therapy primarily for the shoulder which is not helpful the cervical or distal left upper limb symptoms. The patient's medications include, and ibuprofen. The physical exam was significant for limited range of motion of the cervical spine, Spurling and retention signs and positive on the left, and muscle stretch reflexes are one in the biceps, triceps, and brachioradialis bilaterally. Cervical MRI from January 28, 2014 was notable for mild central canal stenosis at C5 - C6 with multilevel variable foraminal stenosis, worsening at C5 - C6 with severe narrowing on the left and moderate to severe narrowing on the right. The patient was diagnosed with chronic left cervical axial pain and cervical radiculitis secondary to foraminal narrowing and central canal stenosis at C5 - C6.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left C5-C6 transforaminal epidural steroid injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**Decision rationale:** Left C5-C6 transforaminal epidural steroid injection is not medically necessary. The California MTUS page 47 states "the purpose of epidural steroid injections is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone is no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment, injections should be performed using fluoroscopy, if the ESI is for diagnostic purposes a maximum of 2 injections should be performed. No more than 2 nerve root levels should be injected using transforaminal blocks. No more than 1 interlaminar level should be injected at one session. 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 6-8 weeks, with the general recommendation of no more than 4 blocks per region per year. Current research does not support a series of 3 injections in either the diagnostic or therapeutic phase. We recommend no more than 2 epidural steroid injections." The ODG states that in terms of sedation with epidural steroid injections, the use of IV sedation (including other agents such as modafinil) may interfere with the result of the diagnostic block, and should only be given in cases of extreme anxiety. Additionally, a major concern is that sedation may result in the inability of the patient to experience the expected pain and parathesias associated with spinal cord irritation. The claimant's physical exam and MRI is consistent with radiculopathy in the distribution of the epidural treatment level; however, there is lack of documentation of failed conservative therapy for the diagnosis to be treated. The medical records stated that the patient under physical therapy for the shoulder without mention of the cervical spine. The requested procedure is not medically necessary per ODG and CA MTUS guidelines.