

<b>Case Number:</b>	CM15-0106929		
<b>Date Assigned:</b>	06/11/2015	<b>Date of Injury:</b>	08/16/2012
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/03/2015

### 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: Arizona, California Certification(s)/Specialty: Family Practice

### 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 injured worker (IW) is a 51 year old male who sustained an industrial injury on 08/16/2012. He reported neck and back pain. The injured worker was diagnosed as having degeneration of cervical intervertebral disc; cervical disc displacement; cervical radiculitis; low back pain; lumbar disc displacement; and lumbar radiculopathy. Treatment to date has included ice, heat, and muscle relaxers. MRI of the cervical spine noted disc height loss and disc desiccation changes at C3 through C6 levels with no paravertebral soft tissue abnormalities. At C3-C4, there was a combination of annular concentric measuring 4.3 mm disc protrusion, and mild to moderate bilateral uncovertebral joint proliferative changes producing mild central and bilateral spinal and neural foraminal stenosis at C3-C4 with decreased anterior subarachnoid space seen, but no definite cord compression or cord edema, and at the C5-C6 level there was left greater than right paracentral and left greater than right lateral 3.2 mm broad based disc protrusion seen, flattening and abutting the anterior left greater than right portion of the thecal sac with mild left greater than right lateral spinal and neural foraminal compressions. There is no extrusion or sequestration of disc material. A central annular tear is seen. There was no cord compression. Currently, the injured worker complains of neck pain that is midline described as an on and off poking sensation. The worker also reports a diffuse headache with mild dizziness positive photo/smell/noise sensitivity and nausea. The neck pain radiates to bilateral upper extremity right greater than left with weakness, heaviness, and numbness in the right hand digit 1-3. There is mild tingling, no spasm, no decreased grasping/fine motor manipulation, and no wrist drop. Pain level is 6-7/10. The worker also complains of daily low back pain rated as a 9/10. He

ambulates with a cane. Pain radiates into the right leg with numbness and paresthesia. There is no swelling. On examination the cervical spine shows asymmetry of the neck and shoulders with tilting of the head and neck to the left. Tenderness to palpation is noted in the trapezial area. On axial compression there is right trapezius tenderness. There is no muscle spasm. Cervical spine range of motion is restricted in forward flexion, backward extension, and right lateral tilt, left lateral tilt, in right and in left rotation. Upper extremity reflexes are 1+ in the right biceps. Upper extremity sensation to light touch is diminished over the C4 dermatome. The left shoulder shows no specific tenderness, and has no deformity. There are no sensory or motor deficits. The right shoulder also shows no specific tenderness, deformity or sensory/motor deficits. The treatment plan includes an epidural steroid injection in the cervical spine, work restrictions on lifting, and a refill of current medications including Norco. Request for authorization is made for a C5-C6 Cervical steroid injection with epidurography and anesthesia.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **C5-C6 Cervical steroid injection with epidurography and anesthesia: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural injections Page(s): 47.

**Decision rationale:** According to the guidelines, the criteria for the use of Epidural steroid injections: Note: The purpose of ESI 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 offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In this case, the claimant did have exam findings of radiculopathy and there were abnormalities in the MRI that can explain the claimant's radiular symptoms. The request for an ESI of C5-C6 is appropriate and medically necessary.