

<b>Case Number:</b>	CM15-0189838		
<b>Date Assigned:</b>	10/02/2015	<b>Date of Injury:</b>	12/11/2013
<b>Decision Date:</b>	11/09/2015	<b>UR Denial Date:</b>	09/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/28/2015

### 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: 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:

The injured worker is a 32 year old male who sustained an industrial injury on 12-11-2013. A review of medical records indicates the injured worker is being treated for status post anterior cervical discectomy and fusion, mild intervertebral disc space narrowing, central spinal stenosis, bursitis left shoulder and slight retro spondylolisthesis L2 on L3 and L3 on L4. Medical records dated 8-28-2015 noted neck pain that radiates bilaterally to the hands and low back pain. Pain is aggravated by activity, bending, prolonged sitting, and standing, twisting, and walking. Pain was rated an 8 out 10 without medications. Physical examination noted tenderness to the cervical spine. Range of motion was moderately limited due to pain. Sensory examination showed decreased sensation in the bilateral upper extremities, and affected dermatome is C6. There was tenderness to the lumbar spine. Range of motion was limited due to pain. Sensory examination showed decreased sensitivity touch along the L5-S1 dermatome in both lower extremities. Straight leg raise in the seated position was positive bilaterally at 70 degrees. Treatment has included surgery, injections, and medications Cyclobenzaprine, Gabapentin, Norco, and Oxycodone. Utilization review form dated 9-15-2015 noncertified 1 bilateral cervical interlaminar epidural steroid injection at the levels of C5-6 under fluoroscopy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral cervical interlaminar epidural steroid injection at the levels of C5-C6 under fluoroscopy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** Review indicates the patient is s/p cervical fusion at C5-6 in March 2014 with continued chronic symptoms. Recent MRI of cervical spine dated 6/15/15 showed mild/mod foraminal stenosis at C5-6, unchanged compared to imaging study of 11/11/14. EMG/NCS on 1/9/14 showed unremarkable findings without evidence of cervical or lumbar radiculopathy or entrapment syndromes. MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); however, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not provided here. Submitted reports have not demonstrated any progressive correlating neurological deficits or remarkable diagnostics to support the epidural injections. There is also no documented failed conservative trial of physical therapy, medications, activity modification, or other treatment modalities to support for the epidural injection. Cervical epidural injections may be an option for delaying surgical intervention; however, there is no surgery planned or identified pathological lesion noted for this individual already s/p cervical discectomy and fusion at C5-6. The Bilateral cervical interlaminar epidural steroid injection at the levels of C5-C6 under fluoroscopy is not medically necessary and appropriate.