

<b>Case Number:</b>	CM14-0111760		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	10/03/1995
<b>Decision Date:</b>	11/25/2014	<b>UR Denial Date:</b>	06/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 injured worker is a 59-year-old female with an original date of injury on October 3, 1995. The patient's industrially related diagnoses include cervical degenerative disc disease, C6 radiculopathy, brachial radiculitis, and depression. An EMG completed on September 12, 2013 revealed right greater than left median nerve abnormalities. According to the utilization review, an unofficial MRI of the cervical spine was submitted with unknown date and no results were provided. However, on a progress note dating 1/22/2014 documents a MRI without contrast from December 14, 2012 showed foraminal stenosis at C3-4, and diffuse annular bulge with right greater than left foraminal stenosis and ventral thecal deformities without central stenosis at C5-6. The patient had medical treatments including Norco, Xanax, Celebrex, and Lyrica. The patient had a cervical epidural steroid injection in April 2013 with documented functional improvement and symptomatic improvement of radicular pain. The patient had conservative treatments such as acupressure, chiropractic, physical therapy, massage, ice, heat, and traction. The disputed issue is a repeat C5-C6 cervical epidural steroid injection. A utilization review determination on June 16, 2014 had noncertified this request. The stated rationale for the denial was according to California MTUS guidelines, 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 to 8 weeks. The documentation submitted for review failed to provide objective functional improvement and decrease in pain. The documentation also failed to provide a date which the prior injection took place; therefore, it is unclear what the patient has had more than 6 to 8 weeks of pain relief. A C5-C6 cervical epidural steroid injection is noncertified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**C5-C6 Cervical Epidural Steroid Injection: Upheld**

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

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

**Decision rationale:** The California Medical Treatment and Utilization Schedule specify on page 47 of the Chronic Pain Medical Treatment Guidelines the following regarding Epidural steroid injections (ESIs): "Recommended as an option for treatment of radicular pain (defined as: pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three." 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" injection in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections." The utilization review reports a lack of imaging finding of radiculopathy. A progress note January 22, 2014 documents a MRI of cervical spine

without contrast from December 14, 2012 showing foraminal stenosis right greater than left at the level of C5 to C6. During that same visit, C6 radiculopathy was demonstrated on physical exam along with a positive Spurling's Maneuver. On a separate progress note from February 25, 2014 documents the patient has had cervical epidural steroid injection in April 2013 with improved function and radicular pain. However, it is not clear if the pain improvement is at least 50% for 6-8 weeks as recommended by the Chronic Pain Medical Treatment Guidelines. In addition, the previous injection site was not specified as noted in the utilization review. Therefore, based on these documented findings, a repeat cervical epidural steroid injection at C5-6 is not medically necessary.