Case Number:	CM14-0087997		
Date Assigned:	07/23/2014	**Date of Injury:**	04/06/2010
Decision Date:	08/27/2014	**UR Denial Date:**	06/02/2014
Priority:	Standard	**Application Received:**	06/10/2014

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 Interventional Spine 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:

This patient is a 53-year-old male with date of injury of 04/06/2010. Per treating physician's report, [redacted], on 05/07/2014, the patient has bilateral cervical pain left worse than the right, left arm symptoms radiating into the hand, right arm down to the elbow, numbness in the right fingertips; 50% of the pain in the neck, 50% in the arms in an intensity of 8/10 to 10/10, constant and worsening. Examination showed diminished range of motion by 50% for flexion, normal strength, normal reflexes. Imaging study from March 2012 showed cervical lordosis, decreased signal intensity, disk space narrowing most significant at C4-C5, C5-C6 with broad-based osteophyte at C4-C5. Plan was interlaminar cervical epidural. 04/30/2014 report is by another physician with current complaints of neck pain radiating into upper extremities, numbness and tingling. Examination is showing limited cervical range of motion, positive Spurling's test with listed assessment of cervical disk disease, cervical radiculopathy, left shoulder impingement. recommendation was for cortisone injection into the subdeltoid bursa under ultrasound guidance. Patient is to follow up with [redacted].

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Cervical Interlaminar Epidural Steroid Injections between 05/28/2014 and 07/12/2014:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines - Epidural steroid injections. Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. Epidural steroid injections (ESIs) (MTUS pgs 46, 47).

Decision rationale: This patient presents with chronic neck and diffuse upper extremity pains. The current request is for interlaminar epidural steroid injection. MTUS Guidelines require clear diagnosis of radiculopathy. Radiculopathy is diagnosed by dermatomal distribution of pain, positive physical examination maneuver with corroborating imaging findings. In this case, patient has diffuse pain in the upper extremities without clear dermatomal distribution. Physical examination did not show any evidence of nerve root problem such as sensory or motor findings. Most importantly, MRI of the C-spine as reviewed by [redacted] does not show any nerve root

lesions such as disk herniation or stenosis that would account for the patient's upper extremity symptoms. Given the lack of clear diagnosis of radiculopathy, recommendation is for denial.