

<b>Case Number:</b>	CM14-0115796		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	01/16/2013
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	06/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2014

### 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 Family Medicine and is licensed to practice in New Jersey. 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 39 year old male was a custody officer when he sustained an injury on January 16, 2013. He was involved in a physical altercation with an aggressive female and fell over a bench to the ground. He reported neck, left shoulder and lower back injuries. On February 26, 2014, the agreed medical evaluator noted continued neck pain with headaches and radiation to both shoulder blades, increased pain with motion, neck muscle tightness, left shoulder pain with decreased range of motion and strength, low back pain with radiation down the left leg and increased pain with walking, and difficulty sleeping at night. The agreed medical evaluator noted that x-rays on January 16, 2013, of the lumbar and cervical spine revealed no abnormality. The diagnoses and results of the injury included lumbar sprain/strain, cervical sprain, muscle spasm, and pain of the neck and back. Initial treatment included x-rays, oral non-steroidal anti-inflammatory drug, muscle relaxer, and pain medications, topical analgesic medication, non-steroidal anti-inflammatory drug injections, cold/hot packs, moist heat, a cervical pillow, and off work. Additional treatment included physical therapy (PT) and acupuncture to the neck; and off work for 4 months. The injured worker received an epidural steroid injection to the back in 2011 for a previous industrial injury. MRI of the cervical spine from 4/5/2013 showed mild right foraminal narrowing of the C4-5 level and mild bilateral foraminal narrowing and a broad-based 2 mm disc bulge effacing the anterior thecal sac with annular tear at the C6-7 level. On August 15, 2013, the injured worker underwent a left shoulder arthroscopy. The injured worker reported he had modified his activities of daily living. On December 9, 2013, the orthopedic surgeon noted the injured worker had undergone a left shoulder arthroscopy with arthroscopic subacromial decompression and debridement 4 months prior. The physician indicated the injured worker benefited from the surgery, had completed postoperative physical therapy, and was to continue his home exercise program. On April 3, 2014, an electromyogram/nerve conduction

velocity revealed mild bilateral carpal tunnel syndrome. On 6/5/14, the worker was seen by his treating physician complaining of neck and right shoulder pain as well as low back pain. The physical exam revealed normal contour of the thoracic and lumbar spine, heel/toe walks without difficulty, moderate left paralumbar muscle spasm upon palpation, quadriceps atrophy, diminished bilateral resisted rotation, positive left straight leg raise, limited range of motion of the spine due to pain, absent deep tendon reflexes bilateral knees, decreased sensation of the left lateral thigh, normal motor strength bilateral lower extremities, and left scapula without abnormalities. Asymmetry of the neck and shoulders upon cervical inspection with head and neck tilted to the left, right trapezius tenderness with axial compression, tenderness to palpation in the trapezial area, and mildly restricted cervical range of motion. The upper extremity sensation was decreased over the cervical 6 and 7 dermatomes, and the strength was intact. Diagnoses included cervical intervertebral disc degeneration, cervical radiculitis, and cervical disc displacement. The physician recommended a cervical steroid injection at the C6 (cervical 6) level with intravenous sedation. The physician documented the injured worker was able to work without restrictions.

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

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

#### **Cervical Steroid Injection to C6: Overturned**

**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 Epidural Steroid Injections Page(s): 46.

**Decision rationale:** The California MTUS Guidelines state that epidural steroid injections are recommended as an option for treatment of lumbar radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) and can offer short-term pain relief, but use should be in conjunction with other rehab efforts, including continuing a home exercise program. The criteria as stated in the MTUS Guidelines for epidural steroid injection use for chronic pain includes the following: 1. radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, 2. Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs, and muscle relaxants), 3. Injections should be performed using fluoroscopy 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, and 8. Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase, and instead only up to 2 injections are recommended. According to the documents provided for review regarding this worker's case,

the most recent MRI findings (from 2013) and recent physical examination findings suggest likely cervical radiculopathy from impingement at the C6 level. It seems reasonable to trial a cervical steroid injection at this point, and therefore the request is medically necessary.

**Monitored Anesthesia:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Epidural steroid injections

**Decision rationale:** The California MTUS Guidelines do not address sedation during epidural injections. However, the Official Disability Guidelines states that there is no evidence to show it may be used routinely. Also, sedation can also result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. However, those patients with significant anxiety may warrant consideration of sedation with a benzodiazepine. Regarding monitored anesthesia care (MAC) during the sedation, the ODG states that with MAC administered by someone other than the surgeon there should be evidence of a pre-anesthetic examination and evaluation, prescription of anesthesia care, completion of the record, and administration of medication and provision of post-op care. Supervision services provided by the operating physician are considered part of the surgical service provided. In the case of this worker, there was no documentation explaining the reason for monitored anesthesia, nor of which medication was intended to be used for sedation during the epidural injection besides "IV sedation". It is unclear why intravenous sedation is being considered over oral benzodiazepines either. Without documentation clarifying this request including reasoning, it will be considered not medically necessary.