

<b>Case Number:</b>	CM15-0183481		
<b>Date Assigned:</b>	09/30/2015	<b>Date of Injury:</b>	01/20/2013
<b>Decision Date:</b>	11/13/2015	<b>UR Denial Date:</b>	08/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2015

### 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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 who sustained an industrial injury on 01-20-2013. According to an initial pain management evaluation and request for authorization report dated 06-18-2015, the injured worker reported constant neck pain with associated headaches. She described shooting pain down both upper extremities to the fingertips. Her arms, hands and fingers were numb and tingled. She had to elevate her arms to get some relief from the upper extremity symptoms. Treatment history included medications and physical therapy. She had just completed 8 sessions of physical therapy, which she felt was beneficial. Current medications included Norco and Trazodone. MRI of the cervical spine performed on 09-04-2014 showed central canal stenosis and mild left neural foraminal stenosis at C3-C4. The endplate osteophyte and annulus disc bulge contacted the cervical cord. There was no cord edema at the C3-C4 level. CD formatted images of the cervical spine scan showed a significant posterior herniation with osteophytosis at the C3-4 segment causing loss of the anterior CSF space and indentation of the anterior thecal sac. There was significant neural foraminal narrowing at the C3-4 segment particularly on the left. There was tenderness and guarding in the cervical paraspinal musculature. Range of motion of the cervical spine was decreased secondary to pain. Sensation testing was decreased in the left upper extremity in the C5, C6 dermatomal distributions. The left arm was weaker than the right one on muscle strength testing. Impression included posterior disc herniation C3-4 causing central and foraminal stenosis, moderate to severe disc height loss C5-6 and cervical radiculopathy. The provider noted that the injured worker had been unresponsive to conservative treatment including physical therapy and anti-inflammatory medications. A cervical epidural injection was recommended under fluoroscopic guidance. According to a progress report with request for

authorization submitted for review and dated 08-03-2015, the injured worker reported neck pain with associated headaches that radiated down the left C5-C6 dermatome that was rated 8-9 on a scale of 1-10 with and without medications. She continued to have mid to lower back pain which radiated down the left posterior thigh that was rated 7-9 without medications and 4-7 with medications. Current medications included Norco, Zanaflex, Maxalt, Trazodone, Celebrex, Omeprazole and topical lotion. Assessment included bilateral cervical radiculopathy, thoracic strain, L5-S1 degenerative disc disease, visual changes, closed head injury, cervicogenic headaches versus neoplasm, C5-C6 degenerative disc disease and central canal stenosis and mild left neural foraminal stenosis at C3- C4. The provider noted that the injured worker had subjective complaints of neck pain and left upper extremity radiculopathy, diagnostic imaging correlated with stenosis, that she had failed physical therapy for the neck, and that medications did no remove her symptoms. Recommendations included authorization for a cervical epidural injection with pain management provider, Norco and a follow up in 4-6 weeks. The injured worker was temporarily partially disabled and was to remain on modified duty. On 08-27-2015, Utilization Review non-certified the request for cervical epidural injection.

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

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

**Cervical epidural injection:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** Accordingly to the MTUS, epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatome 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 the therapeutic phase. We recommend no more than 2 ESI injections.

According to the documents available for review, the IW does have physical exam findings, and pain complaints that are corroborated by imaging studies and as required by the MTUS above. Therefore, at this time, the requirements for treatment have been met and medical necessity has been established. According to the documents available for review, the IW does have physical exam findings, and pain complaints that are corroborated by imaging studies and as required by the MTUS above. Therefore, at this time, the requirements for treatment have been met and medical necessity has been established.