

Case Number:	CM15-0196874		
Date Assigned:	10/12/2015	Date of Injury:	05/27/2004
Decision Date:	11/20/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	10/06/2015

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: Montana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 43 year old nurse with a date of injury of 5/27/04 when she was involved in a motor vehicle accident. The medical records indicated treated for neck, low back and shoulder injury. Diagnoses include brachial neuritis or radiculitis not otherwise specified, degeneration of lumbar or lumbosacral intervertebral disc, and rotator cuff syndrome of shoulder and allied disorders. In the provider notes of 08-07-2015, the worker is seen for re-evaluation. She reported ongoing neck pain and headaches with worsening left arm pain and numbness. Her shoulder pain is daily in the left shoulder with decreased range of motion. She rates her pain as an 8 on a scale of 0-10 without medications and a 2 on a scale of 0-10 with medications. Her pain at exam was 7 on a scale of 0-10. She reports an increase in low back, bilateral shoulder and neck pain with increased left lower extremity and left upper extremity numbness, tingling, weakness and pain involving the left leg and extending to the toes. She reports frequent headaches. Examination of the lumbar sacral spine shows a positive sitting straight leg raise bilaterally. There is no paraspinal muscle spasm. She has decreased sensory to pin on left L4, L5 and S1. Examination of the cervical spine shows decreased upper extremity strength, more so on the left than on the right. Deep tendon reflexes in the upper and lower extremities are normal bilaterally. The worker is working without restriction as a nurse. Treatments have included a C5-6 fusion in 2007, a left shoulder arthroscopy 2008, and she has been seen for depression and anxiety. Medications include Medrol dose pak, Reglan, Senna, Colace, Ibuprofen, Omeprazole, Robaxin, Ranitidine, and Tylenol with codeine, Hydrocodone-Acetaminophen, and Maxalt. A request for authorization was submitted for 1 repeat cervical epidural steroid injection as an outpatient. There is no discussion of the administration or results of an initial cervical epidural steroid injection. A utilization review decision 09-03-2015 non-certified the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 repeat cervical epidural steroid injection as an outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ACOEM Chapter 7-Independent Medical Examinations and consultations, pg 127, the Official Disability Guidelines; Pain (Chronic) and National Guidelines Clearinghouse.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, Epidural steroid injections.

Decision rationale: The MTUS states, in the ACOEM guidelines, that cervical epidural steroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compression. The ODG guidelines further state that epidural steroid injections are recommended as an option to treat radicular pain. No more than 1 interlaminar level should be injected at 1 session. The radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic studies. Recent evidence shows that ESIs should not be recommended in the cervical region, the FDA's Anesthetic and Analgesic Drug Products Advisory Committee concluded. Injecting a particulate steroid in the cervical region, especially using the transforaminal approach, increases the risk for sometimes serious and irreversible neurological adverse events, including stroke, paraplegia, spinal cord infarction, and even death. The FDA has never approved an injectable corticosteroid product administered via epidural injection, so this use, although common, is considered off-label. Injections into the cervical region, as opposed to the lumbar area, are relatively risky, and the risk for accidental injury in the arterial system is greater in this location. (FDA, 2015) An AMA review suggested that ESIs are not recommended higher than the C6-7 level; no cervical interlaminar ESI should be undertaken at any segmental level without pre-procedural review; & particulate steroids should not be used in therapeutic cervical transforaminal injections. (Benzon, 2015) According to the American Academy of Neurology (AAN), ESIs do not improve function, lessen need for surgery, or provide long-term pain relief, and the routine use of ESIs is not recommended. They further said that there is in particular a paucity of evidence for the use of ESIs to treat radicular cervical pain. (AAN, 2015) In this comparative-effectiveness study, no significant differences were found between ESI and conservative treatments. (Cohen, 2014) In this case, we see MRI documentation of degenerative disc disease at C3-4 with a disc-osteophyte complex causing bilateral neuroforaminal narrowing. The recent recommendations do not support injections above the C6-7 level and note that transforaminal cervical injections are subject to significant risk for serious side effects. In this case, the request is for a repeat cervical epidural steroid injection. The medical records do not indicate efficacy of the previous epidural steroid injection. The request does not specify the level for the injection. It is not clear that the injured worker would otherwise undergo open surgical procedures for nerve root compression. The request for cervical epidural steroid injection as an outpatient is not consistent with current recommendations and is not medically necessary.