

Case Number:	CM15-0197611		
Date Assigned:	10/13/2015	Date of Injury:	12/19/2014
Decision Date:	12/01/2015	UR Denial Date:	09/14/2015
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: California, District of Columbia, Maryland
 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 57 year old male, who sustained an industrial injury on 12-19-2014. He has reported injury to the head, neck, and right arm. The diagnoses have included cervical spinal stenosis; cervical spondylosis without myelopathy. Treatment to date has included medications, diagnostics, ice, heat, TENS (transcutaneous electrical nerve stimulation) unit, physical therapy, and activity modification. Medications have included Hydrocodone-Acetaminophen, Nabumetone, Gabapentin, Cyclobenzaprine, Trazodone, Ambien, and Pantoprazole. A progress report from the treating physician, dated 08-07-2015, documented an evaluation with the injured worker. The injured worker reported neck and upper extremity pain; he started the Gabapentin, but he feels this is not that effective for his pain; his previous doctor was giving him Hydrocodone which does help with his pain; his dosage was eventually decreased to 2.5-325mg tablets and he has been using his occasionally as needed for more severe pain; he typically uses this on weekends only; he tries to use Tylenol or Advil instead for his headaches; he tried the Trazodone, but this did not help with his sleep; and he uses Ambien on a nightly basis. Objective findings included he is alert and oriented times three; he does not exhibit acute distress, anxiety, confusion, fatigue, or pain; no abnormalities observed with gait and station; no swelling observed in any extremity; and there is normal muscle tone without atrophy in the bilateral upper and lower extremities. The provider documented that a medical report by another provider noted the cervical MRI as showing "mild stenosis at C3-4, C5-6, and C6-7; there is mild to moderate spinal stenosis at C4-5; there is abnormal signal at this level consistent with focal myelomalacia; and there is moderate bilateral neural foraminal narrowing". The treatment plan has included the request for bilateral cervical epidural steroid injection C4-C5 x 1 each

additional level x 2; cervical epidurogram x 1; and IV sedation. The original utilization review, dated 09-14-2015, non-certified the request for bilateral cervical epidural steroid injection C4-C5 x 1 each additional level x 2; cervical epidurogram x 1; and IV sedation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral cervical epidural steroid injection C4-C5 x 1 each additional level x 2: Upheld

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

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

Decision rationale: Per the MTUS CPMTG epidural steroid injections are used 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 benefit. The criteria for the use of epidural steroid injections are as follows: 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. MRI dated 1/14/15 was referenced, which revealed mild spinal stenosis at C3-C4, C5-C6, and C6-C7; mild to moderate spinal stenosis at C4-C5. Per progress report dated 9/14/15, physical exam revealed 5/5 strength in all upper extremity muscle groups. Decreased sensation was noted about the right C8 dermatome. Reflexes in the biceps, triceps, and brachioradialis were 2+ and symmetrical. Above mentioned citation conveys radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Radiculopathy is defined as two of the following: weakness, sensation deficit, or diminished/absent reflexes associated with the relevant dermatome. These findings are not documented, so medical necessity is not affirmed. As the first criteria are not met, the request is not medically necessary.

Cervical epidurogram x 1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Per the MTUS guidelines with regard to epidural steroid injections: 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. Epidurography is outlining of the epidural space that is visualized when contrast is injected into the epidural space. This is part of epidural steroid injection and is not considered a separate procedure. Providers at times document epidurography for additional billing, but when a needle placed in the epidural space, and epidurography is achieved from injection of contrast, proper needle placement is merely confirmed prior to injection of the steroid. None of the guidelines quoted above discuss epidurography as an additional procedure to ESI. Furthermore, the requested epidural injection was not medically necessary. The request is not medically necessary.

IV sedation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Pain (Chronic), Epidural Steroid Injections: Per the ODG guidelines, Sedation: There is no evidence-based literature to make a firm recommendation as to sedation during an ESI. The use of sedation introduces some potential diagnostic and safety issues, making unnecessary use less than ideal. A major concern is that sedation may result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. This is of particular concern in the cervical region. (Hodges 1999) Routine use is not recommended except for patients with anxiety. The least amount of sedation for the shortest duration of effect is recommended. The general agent recommended is a benzodiazepine. The requested epidural steroid injection was not medically necessary. The request is not medically necessary.