

<b>Case Number:</b>	CM15-0209466		
<b>Date Assigned:</b>	10/28/2015	<b>Date of Injury:</b>	09/23/2010
<b>Decision Date:</b>	12/08/2015	<b>UR Denial Date:</b>	10/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2015

### 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: Ohio, West Virginia

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

### 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 31 year old female who sustained an industrial injury on September 23, 2010. The worker is prescribed regular work duty December 04, 2013. The worker is being treated for: cervical and lumbosacral strain, right wrist strain, cervical herniated disc, cervical myofascitis, cervical radiculopathy, and cervical intervertebral disc degeneration. Subjective: August 12, 2015 she reported complaint of "neck pain;" "pain is still there, radiating down both upper extremities, right side greater." She rates her pain a "7" in intensity out of 10 and reports that bending, twisting, repetitive motion, and work aggravate the pain and rest, medications and "injections in the past have helped to alleviate the pain." Objective: August 12, 2015 noted cervical spine upon palpation of paracervical area with tenderness in the left paraspinal muscles at C5, C6 and C7, and in the right trapezius. There is normal motion chin to chest and range of motion noted without deviation. There is a positive Spurling's on the right with intact sensation to light touch and pinprick in all dermatomes in the upper bilateral extremities; motor sensory without deviation Medication: August 12, 2015 currently taking Gabapentin twice daily. July 01, 2015: Gabapentin and Tizanidine. Treatment: The patient did receive first injection in 2012;"did very well." Acupuncture session completed August 12, 2015 of which "she had responded favorably to treatment and with less pain and discomfort. On August 27, 2015 a request was made for bilateral cervical epidural injection under fluoroscopy at C4 through C5, and MRI of cervical spine which were both non-certified by Utilization Review on October 05, 2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Steroid Bilateral Cervical Epidural Injection Under Fluoroscopic Guidance Levels C4-5 at Doctor's Surgery Center, Cervical Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Epidural steroid injections (ESIs).

**Decision rationale:** MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). 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 were no medical documents provided to conclude that other rehab efforts or home exercise program is ongoing. Additionally, no objective findings were documented to specify the dermatomal distribution of pain. MTUS further defines the criteria for epidural steroid injections to include: 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. ODG notes; 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) There is evidence for short-term symptomatic improvement of radicular symptoms with epidural or selective root injections with corticosteroids, but these treatments did not appear to decrease the rate of open surgery. (Haldeman, 2008) (Benyamin, 2009) Epidural steroid injections should be reserved for those who may otherwise undergo open surgery for nerve root compromise. (Bigos, 1999) Intramuscular injection of Lidocaine for chronic mechanical neck disorders (MND) and intravenous injection of methylprednisolone for acute whiplash were effective treatments. There was limited evidence of effectiveness of

epidural injection of methyl prednisolone and Lidocaine for chronic MND with radicular findings. (Peloso-Cochrane, 2006) The FDA is warning that injection of corticosteroids into the epidural space of the spine may result in rare but serious adverse events, including loss of vision, stroke, paralysis, and death. There is no documentation in the available medical record of a dermatomal distribution of pain/parasthesia in the upper extremities and upper extremity motor, sensory and reflex physical examinations were all normal. A prior MRI is noted in the record but results of it or any earlier EMG are not documented. As such, the request for Steroid Bilateral Cervical Epidural Injection under Fluoroscopic Guidance Levels C4-5 does not meet guideline requirements and is not medically necessary.

### **MRI Cervical Spine: 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), Neck and Upper Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Magnetic resonance imaging (MRI).

**Decision rationale:** ACOEM states Criteria for ordering imaging studies are: Emergence of a red flag, Physiologic evidence of tissue insult or neurologic dysfunction, Failure to progress in a strengthening program intended to avoid surgery and Clarification of the anatomy prior to an invasive procedure. ODG states, not recommended except for indications list below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Indications for imaging - MRI (magnetic resonance imaging): Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present- Neck pain with radiculopathy if severe or progressive neurologic deficit. Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present. Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present. Chronic neck pain, radiographs show bone or disc margin destruction. Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal". Known cervical spine trauma: equivocal or positive plain films with neurological deficit. Upper back/thoracic spine trauma with neurological deficit. The treating physician has not provided evidence of red flags to meet the criteria above. Further, this is a repeat MRI and no documentation has been provided that would indicate there has been a change in this IW's condition that would warrant a re-imaging. As, such the request for an MRI Cervical Spine is deemed not medically necessary.