

Case Number:	CM15-0020404		
Date Assigned:	02/10/2015	Date of Injury:	03/17/2010
Decision Date:	03/27/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/03/2015

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: Pennsylvania
 Certification(s)/Specialty: Internal 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 59 year old female, who sustained an industrial injury on 03/17/2010 due to a fall. Diagnoses included abrasions and contusions to the head and hand, lumbar spine sprain/strain, cervical radiculopathy, lumbar spinal stenosis, and carpal tunnel syndrome. MRI of the cervical spine from 6/5/14 showed degenerative changes of the cervical spine with canal stenosis at multiple levels with neural foraminal narrowing at C3-4 through C6-7. EMG on 10/8/10 showed mild ulnar mononeuropathy at the left elbow, and electrodiagnostic findings suggestive but not diagnostic of left C6-7 radiculopathy. Treatment has included physical therapy, home exercise program, cervical and lumbar epidural steroid injection, cortisone injections to the left shoulder, medications, and a functional restoration program. The injured worker continues to have chronic neck and low back pain, with increased neck pain with radiation to the shoulders associated with numbness in her arms and shoulders. Previous cervical epidural steroid injection on 7/15/14 was reported to result in 50% reduction in pain as documented at the visit on August 13, 2014. At the office visit on 7/30/14, the physician documented that the cervical epidural steroid injection resulted in moderate pain relief, and documented that "it may be that the cervical injections are no longer as effective as they were in the past." Medications for pain in June, July, August, and October 2014 included buprenorphine and Topamax. At a provider visit dated 01/14/2015 the injured worker has reported neck pain that radiates into shoulders. Examination of the cervical spine revealed tenderness to palpation at the paraspinal muscles with associated muscle tension bilaterally, and decreased range of motion. Strength was noted as 4/5 right and left upper extremity arm abduction. Reflexes were 2

plus and equal at the biceps, triceps, and brachioradialis. There was decreased sensation to pinprick along the C7 dermatome on the left. It was noted that after recent completion of the functional restoration program, the injured worker experienced dizziness and visual changes when she flexes her neck, and a neurology consultation to determine if these symptoms were related to the cervical spine was requested. Medications included tramadol, venlafaxine, and Topamax. A more extensive medication list noted at a visit on 1/5/14 also included naproxen. A report from the functional restoration program on 12/18/14 noted that during the program, the injured worker had intermittent vertigo associated with neck movements, which were documented to be likely to be cervicogenic headaches and vertigo symptoms. Work status from June 2014 to January 2015 was noted as permanent and stationary, with work restrictions of no heavy lifting. On 01/28/2015 Utilization Review non-certified Cervical epidural steroid injection at C6-7, Each additional level, Cervical epidurogram, Insertion of cervical catheter, Fluoroscopic guidance, and IV sedation. The CA MTUS, and ACOEM were cited. A treatment appeal letter by the physician dated 1/30/15 notes that the requested services were cervical epidural steroid injection at bilateral C6-7, cervical epidurogram, insertion of cervical catheter, fluoroscopic guidance, and IV sedation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical epidural steroid injection at C6-7: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46. Decision based on Non-MTUS Citation neck and upper back chapter: epidural steroid injections

Decision rationale: The MTUS, chronic pain section, page 46 describes the criteria for epidural steroid injections. Epidural injections are a possible option when there is radicular pain caused by a radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There must be documentation of failure of conservative treatment such as exercises, physical methods, nonsteroidal anti-inflammatory agents, and muscle relaxants. An epidural steroid injection must be at a specific side and level. No more than two nerve root levels should be injected using transforaminal blocks, and no more than one interlaminar level should be injected at one session. The MTUS recommends that any repeat injection be considered based on the degree of pain relief and objective documented functional improvement, including at least 50% pain relief with associated reduction of medication use for 6-8 weeks after the initial injection. Most current guidelines recommend no more than two epidural steroid injections. The MTUS also notes that the American Academy of Neurology reports that epidural steroid injections may lead to an improvement in radicular lumbosacral pain, and that there is insufficient evidence to make any recommendations for the use of epidural steroid injections to treat radicular cervical pain. In this case, the findings were consistent with left C6-7 radiculopathy, with evidence of neural foraminal narrowing on MRI, corroboration with electrodiagnostic studies, and physical exam findings of decreased sensation

along the left C7 dermatome, with documentation of previous conservative treatment. The injured worker had a prior cervical epidural steroid injection on 7/15/14 which was documented to provide 50% pain relief at the August 2014 visit. Medications, however, were not reduced as the progress notes indicate treatment with buprenorphine and Topamax continued from June through October 2014. Work status and restrictions also remained unchanged. The lack of reduction in medication use and lack of improvement in work restrictions are not consistent with functional improvement as required by the guidelines for additional injections. In addition, the documentation suggests that the injured worker has already undergone more than one prior cervical epidural steroid injection. The MTUS notes that most current guidelines recommend no more than two epidural steroid injections, and that there is insufficient evidence to make recommendations for the use of epidural steroid injections to treat cervical radicular pain. A treatment appeal letter by the physician dated 1/30/15 notes that the requested services were cervical epidural steroid injection at bilateral C6-7, however the examination and electrodiagnostic studies showed only left sided findings. In addition, the documentation notes vertigo and visual changes with neck movement related to participation in a functional restoration program possibly related to the cervical spine and which have not yet been fully evaluated. The ODG notes case reports of cerebellar infarction, brainstem herniation, spinal cord infarction, and quadriplegia after cervical transforaminal injection. Due to the lack of guideline recommendation for more than two epidural steroid injections, the lack of functional improvement as a result of the most recent epidural steroid injection, and the potential for complications in light of insufficiently evaluated vertigo and visual changes possibly related to the cervical spine, the request for epidural steroid injection at C6-7 is not medically necessary.

Each additional level: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46.

Decision rationale: The MTUS, chronic pain section, page 46 describes the criteria for epidural steroid injections. Epidural injections are a possible option when there is radicular pain caused by a radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There must be documentation of failure of conservative treatment such as exercises, physical methods, nonsteroidal anti-inflammatory agents, and muscle relaxants. An epidural steroid injection must be at a specific side and level. No more than two nerve root levels should be injected using transforaminal blocks, and no more than one interlaminar level should be injected at one session. The documentation provided states that the request was for epidural steroid injection at bilateral C6-7. No additional levels were discussed. In addition, the guidelines state that no more than one interlaminar level should be injected at one session. The request for "each additional level" is not sufficiently specific, and the guidelines do not recommend that more than one interlaminar level be injected at one session. In addition, the request for cervical epidural steroid injection at C6-7 has been determined to be not medically necessary. For these reasons, the request for each additional level is not medically necessary.

Cervical epidurogram: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Insertion of cervical catheter: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Fluoroscopic guidance: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are 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 cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.