

<b>Case Number:</b>	CM15-0023246		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	02/01/2012
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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: Georgia

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:

This 41-year-old male sustained an industrial injury on 2/1/12, with subsequent ongoing cervical spine pain. Treatment included medications, physical therapy and cervical epidural steroid injections. In a PR-2 date 1/9/15, the injured worker complained of increased numbness and tingling in bilateral arms and hands and continued episodes of nausea and vomiting tied to neck pain flare-ups. Physical exam was remarkable for tightness and tenderness to palpation of bilateral cervical paraspinal muscles and upper trapezius muscles. Current diagnoses included chronic neck pain, cervical radiculopathy, cervicogenic headaches and chronic pain syndrome. The treatment plan included continuing medications (Cymbalta, Trazadone, topical compound cream, Motrin, Topamax), adding Phenergan, awaiting spine surgeon and psychiatric consultation, and continuing to pursue cervical spinal injections for cervical radiculopathy and physical therapy as recommended by the Qualified Medical Evaluation (QME). No QME report or recent radiologic reports were available for review. On 1/27/15, Utilization Review noncertified a request for cervical epidural steroid injection noting lack of objective findings of radiculopathy on physical exam and citing CA MTUS Chronic Pain Medical Treatment Guidelines and ODG Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical epidural steroid injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection (ESI).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 47.

**Decision rationale:** Cervical epidural steroid injection is not medically necessary. The California MTUS page 47 states “the purpose of epidural steroid injections 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 is no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment, injections should be performed using fluoroscopy, if the ESI is for diagnostic purposes a maximum of 2 injections should be performed. No more than 2 nerve root levels should be injected using transforaminal blocks. No more than 1 interlaminar level should be injected at one session. 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 6-8 weeks, with the general recommendation of no more than 4 blocks per region per year. Current research does not support a series of 3 injections in either the diagnostic or therapeutic phase. We recommend no more than 2 epidural steroid injections.” The physical exam lacks objective findings of radiculopathy; therefore, the requested service is not medically necessary.