

<b>Case Number:</b>	CM15-0216822		
<b>Date Assigned:</b>	11/06/2015	<b>Date of Injury:</b>	01/07/2013
<b>Decision Date:</b>	12/18/2015	<b>UR Denial Date:</b>	10/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2015

### 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: Texas, Florida, California

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 62 year old female, who sustained an industrial injury on 1-07-2013. The injured worker is being treated for cervical and lumbar strain, myofascial pain syndrome and lumbosacral radiculopathy. Treatment to date has included multiple surgical interventions, medications, diagnostics, physical therapy, chiropractic care, acupuncture, trigger point injections, epidural injections and medial branch block. Magnetic resonance imaging (MRI) of the cervical spine dated 4-25-2013 showed multilevel concentric uncovertebral hypertrophy with central canal narrowing and neural foraminal narrowing. Per the handwritten Primary Treating Physician's Progress Report dated 8-11-2015, the injured worker reported low back pain with some numbness and weakness of the bilateral legs. Objective findings included positive straight leg raise and limited range of motion of the cervical and lumbar spine. The notes from the provider do not document efficacy of the prescribed medications. Work status was modified. The plan of care included medications and injections. Authorization was requested for left cervical epidural steroid injection (ESI) C7-T1. On 10-16-2015, Utilization Review non-certified the request for left cervical ESI C7-T1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left cervical epidural steroid injection on C7-T1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Cervical and Thoracic Spine Disorders, Epidural Steroid Injection.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Neck, ESI.

**Decision rationale:** This claimant was injured in 2013 and was being treated for cervical and lumbar strain, myofascial pain syndrome and lumbosacral radiculopathy. Magnetic resonance imaging (MRI) of the cervical spine dated 4-25-2013 showed multilevel concentric uncovertebral hypertrophy with central canal narrowing and neural foraminal narrowing. No overt disc herniation corresponding to dermatomal radicular signs and symptoms were noted. The current California web-based MTUS collection was reviewed in addressing this request. They do not specifically isolate the neck area for these injections. The ODG and other sources simply as of late do not support cervical ESI. Per the ODG: 1. Recent evidence: 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) 2. 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) 3. 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) Based on evidence-based review, the request is not medically necessary.