

Case Number:	CM15-0035704		
Date Assigned:	03/04/2015	Date of Injury:	06/18/2003
Decision Date:	04/15/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/25/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 44-year-old male, with a reported date of injury of 04/17/2012. The diagnoses include cervical spondylosis without myelopathy, neck pain, and cervical spine stenosis. Treatments included oral medications and cervical spine surgery. The visit note dated 01/12/2015 indicates that the injured worker complained of severe back pain and burning pain in his neck, with numbness and tingling down his right shoulder and arm. The objective findings include normal muscle tone without atrophy in the bilateral upper extremity. There were no objective findings regarding the cervical spine. It was noted that the injured worker had worsening radicular pain in his right upper extremity. The treating physician requested a cervical epidural steroid injection under fluoroscopic guidance, a cervical epidurogram, insertion of a cervical catheter, and intravenous (IV) sedation to allow the injured worker to further decrease the dosage of medication. On 01/27/2015, Utilization Review (UR) denied the request for a cervical epidural steroid injection under fluoroscopic guidance, a cervical epidurogram, insertion of a cervical catheter, and intravenous (IV) sedation. The UR physician noted that there was no objective MRI report or electromyogram to support the injection; and it was unclear from the documentation provided if the injured worker failed a full course of conservative care prior to the request. The MTUS Chronic Pain Guidelines and the non-MTUS Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical epidural steroid injection under fluoroscopy: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation Official disability guidelines chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Epidural steroid injections (ESIs), therapeutic'.

Decision rationale: The 44 year old patient presents with cervical spondylosis, neck pain, lumbosacral neuritis, lumbar spinal stenosis, lumbar sprain/strain, and cervical spinal stenosis, as per progress report dated 01/22/15. The request is for CERVICAL EPIDURAL STEROID INJECTION UNDER FLUOROSCOPY. The RFA for the case is dated 01/20/15, and the patient's date of injury is 06/18/03. The patient is status post cervical spine surgery. Medications included Cymbalta, Medrol, Pantoprazole, Dilaudid, Gabapentin, Sumatriptan, and Exalgo. The MTUS Guidelines has the following regarding ESI under chronic pain section page 46, recommended as an option for treatment of radicular pain." MTUS has the following criteria regarding ESIs, under its chronic pain section: Page 46,47 "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." For repeat ESI, MTUS states, "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." ODG guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Epidural steroid injections (ESIs), therapeutic', state that at the time of initial use of an ESI (formally referred to as the diagnostic phase as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections. In this case, the patient has never received an ESI for his cervical spine. He suffers from neck pain that radiates to the right arm with numbness and tingling in the right shoulder and arm, as per progress report dated 01/12/15. The treating physician, however, does not document the findings of physical examination neither does the treater provide corroborating evidence in form of imaging or electrodiagnostic studies. The MTUS guidelines require diagnoses of radiculopathy along with corroborating diagnostic studies for ESI. The request IS NOT medically necessary.

Cervical epidurogram: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation website www.ncbi.nlm.nih.gov/pubmed/10319985.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47.

Decision rationale: The 44 year old patient presents with cervical spondylosis, neck pain, lumbosacral neuritis, lumbar spinal stenosis, lumbar sprain/strain, and cervical spinal stenosis, as per progress report dated 01/22/15. The request is for CERVICAL EPIDUROGRAM. The RFA for the case is dated 01/20/15, and the patient's date of injury is 06/18/03. The patient is status post cervical spine surgery. Medications included Cymbalta, Medrol, Pantoprazole, Dilaudid, Gabapentin, Sumatriptan, and Exalgo. The MTUS Guidelines has the following regarding epidural steroid injection under the chronic pain section, pages 46 and 47, recommended as option for treatment of radicular pain defined as pain in the dermatomal distribution and corroborative findings of radiculopathy. In this case, the treating physician does not explain the purpose of this request. Additionally, the patient does not meet the indication for a cervical steroid injection; therefore, the request for epidurogram IS NOT medically necessary.

Cervical catheter: 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), Pain Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Journal of Anesthesia at http://www.apsf.org/newsletters/html/2011/spring/08_epidural.htm.

Decision rationale: The 44 year old patient presents with cervical spondylosis, neck pain, lumbosacral neuritis, lumbar spinal stenosis, lumbar sprain/strain, and cervical spinal stenosis, as per progress report dated 01/22/15. The request is for CERVICAL CATHETER. The RFA for the case is dated 01/20/15, and the patient's date of injury is 06/18/03. The patient is status post cervical spine surgery. Medications included Cymbalta, Medrol, Pantoprazole, Dilaudid, Gabapentin, Sumatriptan, and Exalgo. ACOEM, MTUS and ODG guidelines do not discuss cervical catheters. As per Journal of Anesthesia at http://www.apsf.org/newsletters/html/2011/spring/08_epidural.htm, "If it is felt that steroid placement at higher levels is indicated, it may be safer to introduce an epidural catheter in the upper thoracic spine and advance it under fluoroscopy to the desired level." While the guidelines do not discuss this request, the Journal of Anesthesia supports the use of epidural catheters. However, the patient does not meet the criteria for a cervical steroid injection; therefore, the request for cervical catheter 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 Head chapter, Sedation.

Decision rationale: The 44 year old patient presents with cervical spondylosis, neck pain, lumbosacral neuritis, lumbar spinal stenosis, lumbar sprain/strain, and cervical spinal stenosis, as per progress report dated 01/22/15. The request is for IV SEDATION. The RFA for the case is dated 01/20/15, and the patient's date of injury is 06/18/03. The patient is status post cervical spine surgery. Medications included Cymbalta, Medrol, Pantoprazole, Dilaudid, Gabapentin, Sumatriptan, and Exalgo. ODG guidelines, chapter 'Head' and topic 'Sedation', states that sedation and neuromuscular blockade are appropriate if needed for transport. Short-acting agents are preferred to allow for serial exams. (Colorado, 2005) One study found that analgesia-based sedation with remifentanil permitted significantly faster and more predictable awakening for neurological assessment. (Karabinis, 2004) Two other studies found that a propofol-based sedation with an intracranial pressure control regimen is a safe, acceptable, and, possibly, desirable alternative to an opiate-based sedation regimen in intubated head-injured patients. ODG guidelines support sedation in patient's needing transportation but do not discuss its use in relation to ESI. The treater does not explain the purpose of the request. Additionally, the patient does not meet the criteria for a cervical steroid injection; therefore, the request for IV sedation IS NOT medically necessary.