

Case Number:	CM15-0046987		
Date Assigned:	03/19/2015	Date of Injury:	06/04/2009
Decision Date:	04/24/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/12/2015

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: Montana

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(n) 58 year old male, who sustained an industrial injury on 6/4/09. He reported pain in the shoulders, left wrist and knees related to a fall. The injured worker was diagnosed as having cervical degenerative disc disease with myofascial strain and cervical radiculopathy. Treatment to date has included acupuncture, physical therapy, cortisone injections, lumbar epidural injections and pain medications. As of the PR2 dated 2/4/15, the injured worker reports 6-7/10 pain in the shoulders. He had a cortisone injections in the right shoulder on 6/11/14 which provided 50% pain relief for 3 days. The injured worker does have complaints of neck pain radiating to both arms. Cervical MRI did document degenerative disc disease with severe left neuroforaminal narrowing at C4-5 and C5-6 and moderate canal stenosis at C5-6. The treating physician requested an interlaminar steroid injection at C5-C6.

IMR ISSUES, DECISIONS AND RATIONALES

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

ILESI at C5-C6: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175, Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Procedure index, Epidural steroid injections (therapeutic).

Decision rationale: The MTUS states in the ACOEM guidelines that cervical epidural steroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compression. The Chronic Pain Medical Treatment Guidelines recommend epidural steroid injections (ESIs) as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a series of three, ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. 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 is little information on improved function. 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) See also Epidural steroid injections, series of three. Criteria for the use of Epidural steroid injections: Note: The purpose of ESI 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 offers no significant long-term functional benefit.

- 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. The ODG guidelines further state that epidural steroid injections are recommended as an option to treat radicular pain. No more than 1 interlaminar level should be injected at 1 session. The radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic studies. In this case we see documentation of radiculopathy in a C5-6 dermatomal pattern, corroborated by

MRI documentation of degenerative disc disease with severe left neuroforaminal narrowing at C4-5 and C5-6. There is also moderate canal stenosis at C5-6. The medical records do provide evidence for radiculopathy that would support cervical epidural steroid injection at C5-6. The Utilization Review noted a history of previous ESI that was not helpful. It appears that this was a lumbar injection, not cervical. The prior Utilization Review decision is reversed. The request for interlaminar cervical epidural steroid injection at C5-6 is medically necessary.