

Case Number:	CM15-0089092		
Date Assigned:	05/13/2015	Date of Injury:	09/28/2011
Decision Date:	06/17/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	05/08/2015

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 39 year old female, who sustained an industrial injury on September 28, 2011. The injured worker was working in a shipping and receiving department and developed injuries related to cumulative trauma. The injured worker has been treated for neck, low back, shoulders, elbows, wrists, hands and left foot complaints. The diagnoses have included cervical facet syndrome, lumbar facet syndrome, cervical radiculopathy, lumbar radiculopathy, cervical disc disorder, lumbar degenerative disc disease, right carpal tunnel syndrome, right shoulder impingement syndrome, chronic pain syndrome, left medial and lateral epicondylitis, wrist pain and depression. Treatment to date has included medications, radiological studies, electro-diagnostic studies, physical therapy, epidural steroid injections, heat/ice treatment, medial branch block, stretching, psychotherapy sessions and right carpal tunnel release surgery. Current documentation dated March 25, 2015 notes that the injured worker reported pain in the bilateral elbows, bilateral forearms, bilateral wrists, low back and neck with radiation into both arms. Examination of the cervical and lumbar spine revealed tenderness and a decreased range of motion. Special orthopedic testing of the cervical and lumbar spine was noted to be positive. Examination of the elbows revealed tenderness to palpation over the medial and lateral epicondyle. A Tinel's sign was negative. Bilateral wrist examination revealed diffuse pain, a restricted range of motion and negative special testing. The treating physician's plan of care included a request for one cervical epidural injection at the C7-T1 level.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical epidural injection at C7-T1 (thoracic), Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) 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), Neck, Epidural steroid injections.

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 note that epidural steroid injections (ESIs) are recommended 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. 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) 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. Repeat injections should be based on continued objective documented pain and function response. In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. In this case there is a diagnosis of cervical radiculopathy however the radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic studies. There are no MRI or electrodiagnostic findings to support a C7-T1 epidural steroid injection. As such, the request for Cervical epidural injection at C7-T1 (thoracic), Qty 1 C7-T1 is not medically necessary.