

<b>Case Number:</b>	CM14-0166754		
<b>Date Assigned:</b>	10/13/2014	<b>Date of Injury:</b>	06/01/1998
<b>Decision Date:</b>	11/13/2014	<b>UR Denial Date:</b>	10/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 58 year-old male with a date of injury of 6/1/1998. The patient's industrially related diagnoses include thoracic spondylosis, cervical radiculopathy, cervical degenerative disc disease, fibromyalgia, headache, facet joint syndrome, and muscle spasm. He is status post multiple cervical and lumbar spine surgery including C7-T1 anterior spinal fusion and C6-T1 posterior spinal fusion. The patient has had monthly trigger point injections with temporary relief. The patient has had medical treatment consisting of Endocet, Klonopin, and Lidoderm patches. According to a progress note from 9/9/2014, the patient is currently having physical therapy to neck and back 3 times a week. The patient underwent a cervical epidural steroid injection on 9/22/2014 without documented improvement. The disputed issue is a repeat cervical epidural steroid injection for C5-C6, C6-C7 under fluoroscopy and anesthesia. A utilization review determination on 10/2/2014 had noncertified this request. The rationale for denial was two-fold. First, the diagnostic imaging provided shows no evidence of neuroformaminal narrowing or central canal compromise at the level of C6-C7. Secondly, there was no objective documentation of formal physical therapy or conservative treatments that should be attempted first.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical Epidural Steroid Injection C5-6, C6-7 under fluoroscopy and Anesthesia.:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection section Page(s): 47.

**Decision rationale:** The California Medical Treatment and Utilization Schedule specify on page 47 of the Chronic Pain Medical Treatment Guidelines the following regarding Epidural steroid injections (ESIs)"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. 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 researches do not support "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections." The patient did warrant the first cervical epidural steroid injection on 9/22/2014 because he has C5-C6 posterior disc osteophyte documented on the diagnostic MRI imaging from 7/14/2014, and severe C6-C7 disc space narrowing found on CT cervical spine from 7/14/2014. According to the guidelines, repeat blocks should be based on documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication for 6 to 8 weeks. No such documentation was found in the provided medical record. Therefore, at this time, a repeat cervical epidural steroid injection is not warranted. This request is not medically necessary.