

Case Number:	CM14-0165531		
Date Assigned:	10/10/2014	Date of Injury:	10/01/2006
Decision Date:	05/01/2015	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/08/2014

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. 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: Ohio, North Carolina, Virginia
 Certification(s)/Specialty: Family Practice

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 45-year-old female, who sustained an industrial injury on 10/01/2006. The mechanism of injury was not noted. The injured worker was diagnosed as having cervicalgia, chronic pain syndrome, bicipital tendinitis, myofascial pain, and lumbar post laminectomy. Treatment to date has included diagnostics Motrin and Elavil. She has also had a cervical epidural steroid injection previously but no dates are given. The response was said to be >50%. On 5/20/2014, the injured worker complained of shooting pains down her arms, right greater than left. An electromyogram report and cervical epidural steroid injection were documented as pending. On 8/12/2014, a cervical epidural steroid injection was to be re-requested noting that prior injection (date unspecified) provided greater than 50% relief. Magnetic resonance imaging findings were referenced. At that time, the injured worker complained of pain in her arm and her neck and stated that she could not return to work due to ongoing pain. Physical exam noted decreased range of motion in her neck and functional range of motion in her bilateral upper extremities, but reduced strength limited by pain. She was wearing a brace on her right arm. Current medication use included Motrin and Elavil. The follow-up examination on 9/23/2014 noted complaints of unchanged cervical and radicular symptoms. Medication use included Zanaflex at that time and she was wearing a brace on both wrists.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Cervical Spine Epidural Steroid Injection, as an Outpatient (No Levels Given): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM [https://www.acoempracguides.org/Cervical and Thoracic Spine](https://www.acoempracguides.org/Cervical%20and%20Thoracic%20Spine); Table 2 Summary of Recommendations, Cervical and Thoracic Spine Disorders.

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

Decision rationale: Epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). 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. In this instance, there are no available records to substantiate an actual radiculopathy with a dermatomal distribution. The physical exam findings are non-specific and no MRI report was enclosed. Additionally, there is no cervical level specified for a potential epidural steroid injection. Specification of a level is essential if there is to be correlation with exam and radiographic findings. Therefore, an unspecified cervical epidural steroid injection is not medically necessary based on the information provided for review.