

Case Number:	CM15-0111676		
Date Assigned:	06/18/2015	Date of Injury:	01/17/2002
Decision Date:	07/17/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/09/2015

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: Texas, Florida, California
 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 70 year old female, who sustained an industrial injury on 01/17/2002. She has reported subsequent neck, back, lower extremity pain and headaches and was diagnosed with lumbar and thoracic spine sprain/strain, cervical facet arthropathy, status post anterior cervical discectomy and fusion of C4-C7, lumbar facet arthropathy and spinal dysesthesia. Treatment to date has included medication, physiotherapy and surgery. In a progress note dated 05/08/2015, the injured worker complained of ongoing neck pain associated with cervicogenic headaches and pain radiating down to both upper extremities. Objective findings were notable for tenderness to palpation of the cervical musculature bilaterally with increased muscle rigidity, numerous palpable trigger points, tenderness of the cervical paraspinal muscles, decreased range of motion of the cervical spine with obvious muscle guarding and decreased sensation along the lateral arm and forearm approximately in the C5-C6 distribution bilaterally. A request for authorization of fluoroscopically guided diagnostic catheter directed cervical epidural steroid injection at C5-C6 was submitted due to debilitating pain with ongoing radicular symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluoroscopically guided diagnostic catheter directed cervical epidural steroid injection at C5-C6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175, 181, Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, recent evidence, cervical ESI.

Decision rationale: This claimant was injured back in 2002. There is pain in multiple areas. As of May 2015, there was neck pain and headaches, with pain radiating to both lower extremities. There is reportedly decreased sensation down the lateral forearm in the C5-6 distribution. The current California web-based MTUS collection was reviewed in addressing this request. They do not specifically isolate the neck area for these injections. The ODG and other sources simply as of late do not support cervical ESI. Per the ODG: 1. Recent evidence: ESIs should not be recommended in the cervical region, the FDA's Anesthetic and Analgesic Drug Products Advisory Committee concluded. Injecting a particulate steroid in the cervical region, especially using the transforaminal approach, increases the risk for sometimes serious and irreversible neurological adverse events, including stroke, paraplegia, spinal cord infarction, and even death. The FDA has never approved an injectable corticosteroid product administered via epidural injection, so this use, although common, is considered off-label. Injections into the cervical region, as opposed to the lumbar area, are relatively risky, and the risk for accidental injury in the arterial system is greater in this location. (FDA, 2015) 2. An AMA review suggested that ESIs are not recommended higher than the C6-7 level; no cervical interlaminar ESI should be undertaken at any segmental level without preprocedural review; & particulate steroids should not be used in therapeutic cervical transforaminal injections. (Benzon, 2015) 3. According to the American Academy of Neurology (AAN), ESIs do not improve function, lessen need for surgery, or provide long-term pain relief, and the routine use of ESIs is not recommended. They further said that there is in particular a paucity of evidence for the use of ESIs to treat radicular cervical pain. (AAN, 2015) Based on evidence-based review, the request is not medically necessary.