

<b>Case Number:</b>	CM15-0122190		
<b>Date Assigned:</b>	07/06/2015	<b>Date of Injury:</b>	12/04/2013
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	06/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/24/2015

### 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: Arizona, California  
 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 47 year old male, who sustained an industrial injury on 12/04/2013. He reported a marble top nightstand hit him in the head and neck causing him to fall forward onto his hands and knees. Diagnoses include head trauma with vertigo, dizziness, headaches, cervical spine sprain/strain with radiculopathy, and anxiety and distress. Treatments to date include anti-inflammatory, muscle relaxer, narcotic, and physical therapy. Currently, he complained of increasing pain in the neck and upper back. Weakness and numbness in the right hand was also reported as getting worse. In addition, increased headaches and bursts of anger were reported. Current medications included Xanax, Norco, and Ibuprofen. On 6/8/15, the physical examination documented tenderness and decreased range of motion of the cervical spine. The cervical spine MRI from 10/22/14 revealed multilevel disc bulges and degenerative changes. The plan of care included awaiting authorization for a pain management consultation for possible epidural steroid injection, and consultation with neurologist and psychologist. This appeal request was to review authorization of a cervical epidural steroid injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical epidural steroid injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM chapter on cervical and thoracic spine disorders.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural injections Page(s): 47.

**Decision rationale:** According to the guidelines, the 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. In this case, the claimant did have an MRI which showed encroachment into the theal sac However, clinical exam was not consistent with radiculopathy. As a result, the request for an epidural is not justified and not medically necessary.