

Case Number:	CM15-0170168		
Date Assigned:	09/10/2015	Date of Injury:	07/01/2014
Decision Date:	10/08/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	08/28/2015

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 50 year old female, who sustained an industrial injury on 7-1-2014. The mechanism of injury was a repetitive injury. The injured worker was diagnosed as having cervical radiculopathy, cervical disc disorder and elbow pain. A recent progress report dated 8-12-2015, reported the injured worker complained of neck pain radiating down the bilateral upper extremities, rated 6 out of 10. Physical examination revealed cervical tenderness and restricted range of motion with paravertebral tenderness and positive bilateral cervical facet loading. Cervical magnetic resonance imaging, on 4-10-2015, showed cervical 4-5 and 6-7 disc protrusion and cervical 5-6 posterior disc protrusion and moderate spinal canal stenosis. Treatment to date has included ice, injections, cervical epidural steroid injection, acupuncture, physical therapy and medication management. The physician is requesting cervical epidural steroid injection at cervical 7-thoracic 1 level and x ray of the cervical spine with flexion and extension views. On 8-21-2015, the Utilization Review non-certified the cervical epidural steroid injection at cervical 7-thoracic 1 level and x ray of the cervical spine with flexion and extension views. The epidural steroid injection was non-certified until the results of the electromyography (EMG) are received and the x rays were noncertified due to the spinal surgeon has not reviewed the current radiology studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical epidural steroid injection at C7-T1 level: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: This claimant was injured in 2014 with diagnoses of cervical radiculopathy, cervical disc disorder and elbow pain. As of August, there was still neck pain radiating down the bilateral upper extremities, rated 6 out of 10. Physical examination revealed cervical tenderness and restricted range of motion with paravertebral tenderness and positive bilateral cervical facet loading. Cervical magnetic resonance imaging from April showed cervical 4-5, 5-6 and 6-7 disc protrusion and cervical 5-6 posterior disc protrusion and moderate spinal canal stenosis. Treatment to date has included ice, injections, cervical epidural steroid injection, acupuncture, physical therapy and medication management. 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 no longer 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) The evidence-based guides are adverse. Also, objective improvement outcomes out of prior ESI are not reported. Also, there are no physical exam signs to suggest spinal instability of changing signs and symptoms. Based on evidence-based review, the request is not medically necessary.

Xray of cervical spine with flexion and extension view: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), neck, flexion and extension x-rays.

Decision rationale: As shared previously, this claimant was injured in 2014 reportedly from a repetitive injury with diagnoses of cervical radiculopathy, cervical disc disorder and elbow pain. As of August, there was still neck pain radiating down the bilateral upper extremities, rated 6 out of 10. Physical examination revealed cervical tenderness and restricted range of motion with paravertebral tenderness and positive bilateral cervical facet loading. Cervical magnetic resonance imaging, on 4-10-2015, showed cervical 4-5 and 6-7 disc protrusion and cervical 5-6 posterior disc protrusion and moderate spinal canal stenosis. Treatment to date has included ice, injections, cervical epidural steroid injection, acupuncture, physical therapy and medication management. Objective improvement outcomes out of prior ESI are not reported. The ODG notes in the Neck section, under Flexion and Extension x-rays, that quite simply, they are not recommended as a primary criteria for range of motion. Simple physical examination of range of motion on observation, or with an office goniometer are sufficient. There were no signs on exam suggested of instability or spondylolisthesis, so the request is not supported for that purpose. Also, there are no physical exam signs to suggest spinal instability of changing signs and symptoms. The request was not medically necessary and appropriately non-certified under the evidence-based criteria.