

Case Number:	CM15-0171589		
Date Assigned:	09/11/2015	Date of Injury:	10/25/2013
Decision Date:	10/19/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	08/31/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 53 year old female, who sustained an industrial injury on 10-25-2013. A review of the medical records indicates that the injured worker is undergoing treatment for chronic neck and left upper extremity pain. Medical records (02-10-2015 to 08-10-2015) indicate ongoing neck and left shoulder pain, back pain, right hand pain, bilateral knee pain, and anxiety. Although the records show a slight increase in pain levels, the records also indicate improved activities of daily living and return to work. Per the primary treating physician's progress report (PR), the injured worker has returned to work with restrictions, but that driving long distances tends to aggravate her pain. The physical exams, dated 06-09-2015 and 08-10-2015, revealed little to no changes in symptoms as she continued to experience left-sided neck pain with radiation to the left upper extremity with a pain rating of 10 out of 10 at its worst and 5 out of 10 at its best. Per the PR, dated 08-10-2015, the injured worker reported that her left leg recently gave out on her while trying to navigate some stairs. According to the RP, dated 06-09-2015, the injured worker rated her pain level at 7 out of 10 at its best and 10 out of 10 at its worst. This PR (06-09-2015) also reports decreased sensation and reflexes in the C5 and C6 dermatome distributions on the left. Diagnoses in cervical radiculopathy and cervical spondylosis. Relevant treatments have included cervical epidural steroid injections which the last one proving 50% benefit, physical therapy (PT), chiropractic treatment, work restrictions, and low dose opioid pain medication. A MRI of the cervical spine (09-2014) was available for review and revealed multilevel degenerative disc disease and disc protrusions with foraminal stenosis. The request for authorization (08-10-2015) shows that the following service was requested: cervical epidural steroid injection (x1) with fluoroscopy and monitored anesthesia. The original utilization review (08-18-2015) denied the request for a cervical epidural steroid injection (x1) with fluoroscopy and monitored anesthesia based on the lack of greater than 50% benefit lasting 6 weeks or more, and lack of functional improvement and reduction in medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Epidural Injection times 1 with fluoroscopy and monitored anesthesia care:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: Based on the 8/10/15 progress report provided by the treating physician, this patient presents with unchanged left neck pain radiating to the left upper extremity, with pain rated 5/10 at its best, and 10/10/ at its worst. The treater has asked for cervical epidural injection times 1 with fluoroscopy and monitored anesthesia care on 8/10/15. A prior 6/24/15 report requested cervical epidural steroid injection at left C5 with fluoroscopy and monitored anesthesia care "because the patient has severe anxiety." The request for authorization was not included in provided reports. The patient is s/p a recent cervical epidural steroid injection which helped about 50% per 8/10/15 report. The 6/29/15 report states that there is numbness in the left upper extremity mainly along the C5-6 distribution, along with radiating symptoms. The patient states that driving long distances aggravates her neck pain per 8/10/15 report. The patient states that her left leg recent gave out when navigating the stairs per 8/10/15 report. The patient has failed physical therapy but has not yet had acupuncture per 6/29/15 report. The patient's work status is currently employed per 8/10/15 report. MTUS, Epidural steroid injections section, pg 46: 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: 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. The patient had a prior cervical epidural steroid injection of unknown date between 2/10/15 and 6/9/15 reports. However, none of the included reports mention specifically the duration of pain relief from prior cervical epidural steroid injection, although 8/10/15 report states it "helped about 50%." ODG guidelines state that

repeat epidural steroid injections are to 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, which is not documented for this patient's prior cervical epidural steroid injection. In addition, MTUS states, "there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain." Therefore, the requested repeat epidural steroid injection for cervical spine IS NOT medically necessary.