

<b>Case Number:</b>	CM15-0174614		
<b>Date Assigned:</b>	09/16/2015	<b>Date of Injury:</b>	01/21/2015
<b>Decision Date:</b>	10/20/2015	<b>UR Denial Date:</b>	08/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2015

### 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: Montana

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 57 year old male who sustained an industrial injury on 1-21-15 when he fell off the bed of a truck. Diagnoses included cervical spondylosis and radiculopathy, and cervical facet joint syndrome. The treatment note on 8-13-15 documents complaint of frequent tingling, numbing, cramping neck pain without radiation. His current pain level is 5 out of 10. Medications give 80% relief of pain. On physical exam of the cervical spine there was limited range of motion due to pain, palpable trigger points in the muscles of the head and neck, positive Spurling sign on the right; the lumbar spine, shoulder, wrists exams were unremarkable. In the 7-17-15 note the injured worker reported radiation of neck pain down the bilateral upper extremities into the fingers for the last 7 months with a pain level of 2 out of 10. Diagnostics include MRI of the cervical spine (6-26-15) showing disc osteophyte complex at C5-6, bilateral facet narrowing, severe bilateral foraminal stenosis, disc bulging C4-7. Treatments to date include medications: Flexeril, nabumetone; Naprosyn, tramadol; cervical epidural steroid injection (7-22-15) with 50% improvement in neck pain, 60% improvement in function, range of motion and decreased medication use; he has failed ice, heat, more than 12 sessions of physical therapy, intramuscular steroid and non-steroidal anti-inflammatory medications. In the progress note dated 8-13-15 the treating provider's plan of care included a request for a second cervical epidural steroid injection having demonstrated over 50% reactive pain improvement from the first injection with improvement in function. He continues to have significant residual radicular pain. On 8-27-15 utilization review evaluated and non-certified the request for one bilateral cervical epidural steroid injection at C5-6 based on no documentation of the amount of time the

pain medication was reduced, no documentation of regarding concurrent physical therapy or home exercise program.

## **IMR ISSUES, DECISIONS AND RATIONALES**

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

### **1 Bilateral cervical epidural steroid injection at C5-C6: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, Epidural steroid injection (ESI).

**Decision rationale:** The MTUS states in the ACOEM guidelines that cervical epidural steroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compression. The ODG guidelines state that epidural steroid injections are not recommended based on recent evidence, given the serious risks of this procedure in the cervical region, and the lack of quality evidence for sustained benefit. While not recommended, cervical ESIs may be supported using Appendix D, Documenting Exceptions to the Guidelines, in which case: Criteria for the use of Epidural steroid injections, therapeutic: Note: The purpose of ESI is to reduce pain and inflammation, 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 only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (8) Repeat injections should be based on continued objective documented pain and function response. (9) 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. (10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. (11) Cervical and lumbar epidural steroid injection should not be performed on the same day; (12) Additional criteria based on evidence of risk: (a) ESIs are not recommended higher than the C6-7 level; (b) Cervical interlaminar ESI is not recommended; & (c) Particulate steroids should not be used. (Benzon, 2015) In this case the radiculopathy is corroborated by the cervical MRI on 6/26/15. In this case, the medical records do document radiculopathy on physical examination, corroborated by the cervical MRI on 6/26/15. Additional records provided document a review of the original

UR, dated 8-27-15, with certification of the bilateral cervical epidural steroid injection at C5-C6 on 9-3-15. On 9-11-15, the injured worker had a T1-2 epidural steroid injection with catheter to the C6-7 level. No additional epidural steroid injections would be recommended without documentation of adequate response to this most recent injection. Note also that the ODG guidelines do not recommend epidural steroid injections higher than the C6-7 level. The request for 1 bilateral cervical epidural steroid injection at C5-C6 is not medically necessary.