

Case Number:	CM15-0062841		
Date Assigned:	04/08/2015	Date of Injury:	09/26/2008
Decision Date:	05/13/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	04/02/2015

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 (IW) is a 63-year-old male who sustained an industrial injury on 09/26/2008. Diagnoses include degeneration of cervical intervertebral disc, cervical disc displacement and cervical radiculitis. Treatment to date has included medications, ice/heat, rest and physical therapy (PT). Diagnostics performed to date included x-rays, EMG/NCS and MRIs. According to the progress notes dated 2/10/15, the IW reported pain in the neck and the left shoulder, radiating into the left arm with numbness and weakness and with paresthesia in the left hand. A request was made for C5-C6 cervical steroid injections, epidurography and monitored anesthesia care for treatment of daily neck pain that is increasing and interfering with activities of daily living.

IMR ISSUES, DECISIONS AND RATIONALES

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

C5-6 Cervical Steroid Injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI
Page(s): 46-47.

Decision rationale: Based on the 2/10/15 progress report provided by the treating physician, this patient presents with worsening bilateral cervical pain with headaches, radiating into the left shoulder and left arm with numbness/weakness, and paresthesia in the hand, with pain rated 6-7/10 on VAS scale. The treater has asked for C5-6 CERVICAL STEROID INJECTION on 2/10/15 "based on the fact that patient's neck pain symptoms are daily." The request for authorization was not included in provided reports. The patient is s/p unspecified cervical injection with 60% relief and was able to perform daily activities of daily living per 2/10/15 report. The utilization review letter dated 3/11/15 states that the patient has had prior cervical epidural steroid injections. The patient's currently medications are methadone and restoril per 2/10/15 report. The patient has not had prior surgeries to the cervical spine or lumbar spine per review of reports. The patient is s/p medial branch nerve block at lumbar level bilateral L2-4 from 9/3/14 with 50-80% improvement that is ongoing as of 10/15/14 report. The patient is currently disabled as of 2/10/15 report, and was not working as of 10/15/14 report. MTUS Guidelines has the following regarding ESI under chronic pain section page 46 and 47, "Recommended as an option for treatment of radicular pain." MTUS has the following criteria regarding ESI's, under its chronic pain section: Page 46, 47: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 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. For repeat ESI, MTUS states, "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." The utilization review letter dated 3/11/15 referenced a cervical MRI performed on 9/30/10 which revealed "mild to moderate spondylosis of the cervical spine from C3 through C7; a 5mm posterior central C4-5 disc herniation that causes mild spinal canal stenosis; and 1 to 3mm posterior disc bulges/protrusions at C3-4, C5-6, and C-6-7." The patient does mention radicular symptoms into the left shoulder/arm, and diminished sensation over the C5-6 dermatomes per 2/10/15 report. However, the patient appears to have had prior cervical epidural steroid injections and had an unspecified cervical injection with 60% pain relief as referenced per 2/10/15 report. There is no documentation, however, regarding the duration of pain relief or of any reduction in medication usage following the injection. The request does not meet guideline criteria for the repeat injection. Therefore, the request for a repeat cervical epidural steroid injection IS NOT medically necessary.

Epidurography: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI
Page(s): 46-47. Decision based on Non-MTUS Citation American Journal of Nueroradiology at

<http://www.ajnr.org/content/20/4/697.full> Official disability guidelines chapter 'Pain (Chronic)' and topic 'Epidural Steroid Injections (ESIs).

Decision rationale: Based on the 2/10/15 progress report provided by the treating physician, this patient presents with bilateral cervical pain with headaches, and left shoulder pain, radiating into the left arm with numbness/weakness, and paresthesia in the hand, with pain rated 6-7/10 on VAS scale. The treater has asked for EPIDUROGRAPHY on 2/10/15. The request for authorization was not included in provided reports. The patient is s/p unspecified cervical injection with 60% relief and was able to perform daily activities of daily living per 2/10/15 report. The patient's currently medications are methadone and restoril per 2/10/15 report. The patient has not had prior surgeries to the cervical spine or lumbar spine per review of reports. The patient is currently disabled as of 2/10/15 report, and was not working as of 10/15/14 report. The MTUS, ACOEM and ODG guidelines do not discuss Epidurography specifically. The procedure, however, done along with an ESI, as per study published in the American Journal of Nueroradiology at <http://www.ajnr.org/content/20/4/697.full>. Regarding ESI, MTUS has the following to say under chronic pain section page 46 and 47, "Recommended as an option for treatment of radicular pain." MTUS has the following criteria regarding ESI's, under its chronic pain section: Page 46, 47 "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." ODG guidelines, chapter 'Pain (Chronic)' and topic 'Epidural Steroid Injections (ESIs)', state "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." In this case, the patient does not meet the indication for a repeat cervical steroid injection; therefore, the epidurography is not necessary. Furthermore, injections of contrast to ensure proper placement of the injection is part of the ESI procedure. Additional billing for epidurogram is not discussed in any of the guidelines. The requested epidurography is not medically necessary.

Monitored Anesthesia Care: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines chapter 'Pain (Chronic)' and topic 'Epidural Steroid Injections (ESIs).

Decision rationale: Based on the 2/10/15 progress report provided by the treating physician, this patient presents with bilateral cervical pain with headaches, and left shoulder pain, radiating into the left arm with numbness/weakness, and paresthesia in the hand, with pain rated 6-7/10 on VAS scale. The treater has asked for MONITORED ANESTHEISA CARE on 2/10/15. The request for authorization was not included in provided reports. The patient is s/p unspecified cervical injection with 60% relief and was able to perform daily activities of daily living per 2/10/15 report. The patient's currently medications are methadone and restoril per 2/10/15 report. The patient has not had prior surgeries to the cervical spine or lumbar spine per review of reports. The patient is currently disabled as of 2/10/15 report, and was not working as of 10/15/14 report. ODG guidelines, chapter 'Pain (Chronic)' and topic 'Epidural Steroid Injections (ESIs)', state "sedation is not generally necessary for an ESI but is not contraindicated. As far as monitored anesthesia care (MAC) administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of post-op care. Supervision services

provided by the operating physician are considered part of the surgical service provided." In this case, the treater does not discuss the need for monitored anesthesia care. There is no evidence of pre-anesthetic exam and evaluation, as required by ODG. Furthermore, as the request for the repeat cervical ESI is not indicated, the monitored anesthetic care IS NOT medically necessary as well.