

Case Number:	CM13-0036562		
Date Assigned:	12/18/2013	Date of Injury:	04/21/2001
Decision Date:	03/18/2014	UR Denial Date:	10/11/2013
Priority:	Standard	Application Received:	10/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a patient who has a chronic history of pain. She reports that she worked for the [REDACTED] for several years and sustained injuries to her back, neck and her entire right side on the body through her work. She was on [REDACTED]. She and her husband has moved to [REDACTED] where she was being followed up for her pain with a rehab clinic there, but they felt she needed surgery for her problems and so referred her back to the state of [REDACTED]. The patient has since been back here, has been working to find a primary provider, but has been unable to establish care with anyone. The patient reports that she has a history of degenerative joint disease, that she has slipped disk in both her cervical and lumbar spine, that she has carpal tunnel syndrome in the right side as well as arthritis and muscle spasms that keep her up at night. She reports that she has not been able to get a full night's sleep. That she has run out of her medication from her provider back in [REDACTED] and they will not refill it as they are unable to evaluate her there. Patient denies any new injury and she denies any new symptoms but the patient does has intermittent numbness in her right leg. This is her baseline. Denies any further weakness or tingling. The patient reports that the medications she has been taking includes Soma 350mg 4 times a days with Norco 10/325 4 times a day. According to the July 8, 2013 progress note by [REDACTED], the original injury occurred while the patient was working as a detention officer he got into a fight with an inmate and has been retired from work since 2003. She's been treated with physical therapy and epidural steroid injections but continues to have neck pain to her right shoulder blade that travels down her and to long and ring fingers. She also has headaches at the base of the skull. She cannot tolerate nonsteroidal anti-inflammatory medications as she has a history of gastrointestinal bleed. She does have a long history of narcotic use. She currently takes Norco and soma and does not have a regular doctor prescribe these medications. She has not had any recent physical therapy has not had a recent epidural

steroid injection over 10 years. She also notices some problems with her balance and occasional and weakness. Findings: Cervical spine examination shows decreased range of motion with rotation 35° to the left and 30° the right painless motion. There is no tenderness noted in cervical spine. Motor strength in the upper extremities is 5/5 equal bilaterally. Sensation is C6 decreased sensation of the radial forearms some and index finger but otherwise normal. Pain scale is 6/10 Patient has continued neck and arm pain with continued need for treatment a cervical MRI is needed to evaluate this candidate. X-ray of the cervical spine was ordered but no results noted. MRI of cervical spine is requested diagnosis pain in joint cervical spine, cervicalgia, brachial neuritis or radiculitis. Cervical MRI dated July 17, 2013 shows mild cervical spondylosis with bulging disc at C3-C4 greater than C2- C3 no significant canal stenosis, mild foramina! stenosis at C3-C4 C4-C5 and C5-C6 as well as C6-C7. There is mild bilateral facet hypertrophy at C7-T1. There are small perineural cysts at C5-C6 and C6-C7 the screws were read by [REDACTED]. According to the comprehensive initial pain management consultation by [REDACTED], date 8/08/2013, the patient is suffering from chronic pain syndrome due to her work injury. The patient has a sister and apparently her father with history of substance abuse and addiction as per the patient. Patient continues to have pain in neck going down the right upper extremity and shoulder and has difficulty sleeping. She is in physical therapy, acupuncture, and chiropractic but nothing really has helped in the past and has had no relief with epidural steroid injections, her pain level is 7-8/10. Objective findings: Cervical spine examination shows full extension and cervical rotation right and left are full. Sensation to pinprick is normal in both upper extremities and motor strength is normal as well as reflexes. There is no tenderness to palpation in the cervical spine cervical facet joints were several cervical junction. Lumbar spine examination is done which is full sensation is normal reflexes are normal there is no tenderness to palpation. Straight leg raising negative. Diagnosis: Cervical spondylosis, cervical degenerative disease, cervical radiculitis, lumbar radiculitis, lumbosacral spondylosis. Treatment plan: MRI lumbar spine with contrast is being ordered the patient be started on Lyrica 100 mg at bedtime, fentanyl patch 12 meg topically every 72 hours and tizanidine 4 mg 3 times a day for pain control. She does request to stop taking soma and Norco. She is provided on her own request Flector patches with Tegaderm dressings. A urine drug screen was requested. According to the follow-up progress note by [REDACTED] dated August 22, 2013, the patient's pain level was 6/10 with radiation to the bilateral shoulders as well as lumbar spine and buttock area. Cervical spine: Range of motion is full motor and sensory are intact. Although Spurling sign was negative there was severe tenderness on palpation of the facet joints of the bilateral cervical spine especially at C6-C7 level no spinous process tenderness to palpation Lumbar spine examination shows full range of motion and some mild facet tenderness bilaterally. Treatment plan: Refill Lyrica, fentanyl, tizanidine, and Flector patches. The patient will be given fentanyl patches 12 meg 5 patches. She'll be scheduled to have an ultrasound-guided shoulder injection in the future and a cervical epidural steroid injection to control her cervical pain. Lumbar spine MRI will be also requested. Motor strength in the upper extremities is 5/5 equal bilaterally. Sensation is C6 decreased sensation of the radial forearms some and index finger but otherwise normal. Pain scale is 6/10. Patient has continued neck and arm pain with continued need for treatment a cervical MRI is needed to evaluate this candidate. X-ray of the cervical spine was ordered but no results noted. MRI of cervical spine is requested diagnosis pain in joint cervical spine, cervicalgia, brachial neuritis or radiculitis. Cervical MRI dated July 17, 2013 shows mild cervical spondylosis with bulging disc at C3-C4 greater than C2- C3 no significant canal stenosis, mild foramina! stenosis at C3-C4 C4-C5 and C5-C6 as well as C6-C7. There is mild bilateral facet hypertrophy at C7-T1. There are small perineural cysts at C5-C6 and C6-C7 the screws were read by [REDACTED]. According to the comprehensive initial pain management consultation by [REDACTED], date 8/08/2013, the patient is suffering from chronic pain syndrome due to her work injury. The patient was being seen by [REDACTED] for pain control but in case of increasing pain

medication and was requesting a visit with myself. The patient has a sister and apparently her father with history of substance abuse and addiction as per the patient. Patient continues to have pain in neck going down the right upper extremity and shoulder and has difficulty sleeping. She is in physical therapy, acupuncture, and chiropractic but nothing really has helped in the past and has had no relief with epidural steroid injections, her pain level is 7-8/10. Objective findings: Cervical spine examination shows full extension and cervical rotation right and left are full. Sensation to pinprick is normal in both upper extremities and motor strength is normal as well as reflexes. There is no tenderness to palpation in the cervical spine cervical facet joints were several cervical junction. Lumbar spine examination is done which is full sensation is normal reflexes are normal there is no tenderness to palpation. Straight leg raising negative. Diagnosis: Cervical spondylosis, cervical degenerative disease, cervical radiculitis, lumbar radiculitis, lumbosacral spondylosis. Treatment plan: MRI lumbar spine with contrast is being ordered the patient be started on Lyrica 100 mg at bedtime, fentanyl patch 12 meg topically every 72 hours and tizanidine 4 mg 3 times a day for pain control. She does request to stop taking soma and Norco. She is provided on her own request Flector patches with Tegaderm dressings. A urine drug screen was requested. According to the follow-up progress note by [REDACTED] dated August 22, 2013, the patient's pain level was 6/10 with radiation to the bilateral shoulders as well as lumbar spine and buttock area. Cervical spine: Range of motion is full motor and sensory are intact. Although Spurling sign was negative there was severe tenderness on palpation of the facet joints of the bilateral cervical spine especially at C6-C7 level no spinous process tenderness to palpation Lumbar spine examination shows full range of motion and some mild facet tenderness bilaterally. Treatment plan: Refill Lyrica, fentanyl, tizanidine, and Flector patches. The patient will be given fentanyl patches 12 mg 5 patches. She'll be scheduled to have an ultrasound-guided shoulder injection in the future and a cervical epidural steroid injection to control her cervical pain. Lumbar spine MRI will be also requested. There is a request for authorization by [REDACTED], dated November 14, 2013 and is requesting to office visits and a urine drug screen. The patient had a urine drug screen on September 6, 2013 which showed positive for benzodiazepines at 481. Procedure and her screen dated October 28, 2013 shows positive for benzodiazepines at 687 and methamphetamine at 354. Apparently a urine drug screens are done in the office dipstick method. According to the patient's medications noted, it is not clear why the patient is positive for benzodiazepines and most recently methamphetamines so continue drug screening is reasonable in a conversation with the patient should occur regarding the use positive drug findings which are inconsistent with those medications being prescribed according to the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical transforaminal epidural steroid injection C6-7: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: Medical records from [REDACTED] on 9/5/2013 indicated CS-7 foramina! stenosis on MRI and TRANSFORAMINAL RIGHT CS-7 FOR BOTH DIAGNOSTIC AND THERAPEUTIC SYMPTOMS was requested. However there was no collaborative electro-diagnostic studies obtained as stipulated by the guidelines. Therefore the

request for Cervical Epidural injection at c6-7 is not medically necessary.