

Case Number:	CM13-0044952		
Date Assigned:	12/27/2013	Date of Injury:	10/22/2012
Decision Date:	04/24/2014	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	10/30/2013

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. The expert reviewer is Board Certified in Orthopedic Surgery, 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 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/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 39 year old male sustained an industrial injury on 10/22/12 when he fell off a ladder breaking his nose and injuring his spine and left shoulder, elbow, and wrist. He underwent an open reduction and nasal septal reconstruction on 10/29/12. The 11/20/12 cervical MRI documented disc desiccation from C2/3 through C5/6 and mild broad based disc bulges at C3/4, C4/5, C5/6, and C6/7 with mild spinal canal narrowing. The 11/19/12 bilateral upper extremity nerve conduction study findings were consistent with bilateral carpal tunnel syndrome, left greater than right, and possible cervical radiculopathy. The 9/26/13 treating physician report cited constant neck and low back pain increased with repetitive neck bending, lifting, carrying, hand and arm movements, and lifting over 5 pounds. Pain was reduced with heat, cold, rest, and medications. The patient also complained of sleep difficulties, headaches, and decreased energy levels. The patient was 10-days status post lumbar epidural steroid injection with reported pain reduction and functional improvement. Cervical exam findings documented mild to moderate loss of cervical range of motion, diminished left biceps and brachioradialis reflexes, left C7 sensory deficit, left C7 myotomal weakness, severe suboccipital tenderness, and severe C3/4 through C7/T1 paraspinal muscle tenderness, spinal tenderness, and bilateral facet joint tenderness. Cervical foraminal compression was positive bilaterally; extension compression testing was positive on the left. The diagnosis included cervical intervertebral disc displacement without myelopathy C3/4 to C6/7, brachial neuritis or radiculitis left C7, cervical spinal stenosis C3/4 to C6/7, and cervical facet joint syndrome. The treatment plan recommended an initial diagnostic cervical epidural steroid injection at C3/4, C4/5, C5/6, and C6/7 as the patient had cervical pain with a focal dermatomal radicular pain distribution and had been unresponsive to conservative treatment for 4 to 6 weeks prior to this exam. A cervical facet joint block at the medial branch at levels C4/5, C5/6, and C6/7 bilaterally was recommended, followed by a

rhizotomy if successful. The treatment plan also included internal medicine clearance, psychological evaluation, and lab testing to include free and total testosterone, complete blood count, and PSA. Records indicated that the patient underwent lumbar medial branch blocks on 7/29/13 and lumbar epidural steroid injections on 9/16/13 with pre-injection testing on 7/8/13 including CBC, chemistry panel, and EKG, all reported within normal limits. The 10/11/13 utilization review partially certified the request for cervical epidural steroid injections limited to 2 levels and partially certified the lab work requests limited to one CBC. The requests for cervical facet joint blocks, internal medicine consult, and psychological evaluation were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE CERVICAL EPIDURAL STEROID INJECTION AT C3-4, C4-5, C5-6, C6-7: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines recommend epidural steroid injections for the treatment of radicular pain. Guideline criteria includes radiculopathy documented by physical exam and corroborated by imaging studies and/or electrodiagnostic testing, initial unresponsiveness to conservative treatment, and a maximum of two injections for diagnostic purposes. Guideline criteria have not been met. The patient had neck and radicular pain. Exam findings were suggestive of a C7 radiculopathy but imaging and electrodiagnostic findings were not definitive. Cervical MRI documented disc desiccation from C2/3 through C5/6 and mild disc bulges from C3/4 through C6/7 with mild spinal canal narrowing and no nerve root compression. The upper extremity nerve conduction studies suggested a possible cervical radiculopathy. The utilization review on 10/11/13 partially certified this cervical epidural steroid injection request limited to 2 levels between C3 and C7. There is no compelling reason to support additional injections. Therefore, this request for one cervical epidural steroid injection at C3/4, C4/5, C5/6, and C6/7 is not medically necessary and appropriate.

ONE CERVICAL FACET JOINT BLOCK AT C4-5, C5-6, C6-7 BILATERALLY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter, section on Facet joint diagnostic blocks.

Decision rationale: The MTUS Chronic Pain Guidelines do not provide recommendations for facet joint blocks for chronic cervical injuries. The Official Disability Guidelines recommend diagnostic blocks for facet nerve pain when the clinical presentation is consistent with facet joint pain, signs, and symptoms. Facet joint physical findings generally include axial neck pain, facet tenderness to palpation, decreased range of motion, and absence of radicular and/or neurologic findings. Recommendations for medical branch blocks are limited to patients with cervical pain that is non-radicular and no more than 2 levels bilaterally. Guideline criteria have not been met. The patient had neck and radicular pain. Objective findings included severe facet tenderness and decreased range of motion but also positive C7 neurologic findings. The request exceeds 2 levels bilaterally. Therefore, this request for cervical facet joint block at C4/5, C5/6, and C6/7 bilaterally is not medically necessary and appropriate.

ONE MD CONSULT FOR CLERANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 127.

Decision rationale: Records indicated that the patient should receive clearance from an internal medicine specialist prior to proceeding with the injections. The MTUS Guidelines do not address the medical necessity of internal medicine clearances prior to injection procedures. In general, the ACOEM guidelines recommend the use of a consultant when the plan or course of care may benefit from additional expertise. Guideline criteria have not been met. There is no documentation of co-morbidities or current medical complaints to warrant a specialist referral. Recent CBC, blood chemistries and an EKG were all within normal limits. Additionally, this patient has recently undergone other injection procedures without reported difficulty. Therefore, this request for one M.D. consult for clearance is not medically necessary.

ONE PSYCHOLOGICAL EVALUATION: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 127.

Decision rationale: The California MTUS guidelines do not address the medical necessity of psychological evaluation prior to injection procedures. In general, the ACOEM guidelines recommend the use of a consultant when psychosocial factors are present. Guideline criteria have not been met. There is no documentation of psychosocial factors to warrant a psychology referral. There are no specific somatic manifestations of emotional states or psychological problems reported or diagnosed. Additionally, this patient has recently undergone other injection procedures without reported difficulty. Therefore, this request for psychological evaluation is not medically necessary.

ONE BLOOD DRAW FOR FREE/TOTAL TESTOSTERONE, CBC, AND PSA: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medical Services Commission. Testosterone testing protocol. Victoria (BC): British Columbia Medical Services Commission; 2011 Jun 1. 4p., and the American Cancer Society (ACS). American Cancer Society guideline for the early detection of prostate cancer: update 20

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Testosterone replacement for hypogonadism Page(s): 110. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back, and the American Cancer Society Guideline for Early Detection of Prostate Cancer.

Decision rationale: Guidelines support the use of testosterone testing in men who are taking long term, high dose oral opioids and exhibit symptoms or signs of hypogonadism. The Official Disability Guidelines state that a complete blood count is indicated for patients with diseases that increase the risk of anemia. Evidence based medical guidelines recommend PSA screening for males under 40 only when there is appreciably higher risk, such as those with a family history of prostate cancer before age 65. Guidelines criteria have not been met. There is no evidence that the patient had been on long-term high dose opioids or has symptoms or signs of hypogonadism. A complete blood count and chemistry panel were performed on 7/8/13 and were within normal limits. Past medical history is negative for any serious illness or bleeding problem and family history is negative for any major illness. The 10/11/13 utilization review recommended partial certification of this request for lab work limited to a CBC. Therefore, this request for one blood draw for free/total testosterone, CBC, and PSA is not medically necessary.