

Case Number:	CM13-0052134		
Date Assigned:	12/27/2013	Date of Injury:	05/31/2011
Decision Date:	03/12/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	11/15/2013

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, Florida, Maryland, and Washington, D.C. 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:

The patient is a 55-year-old female who sustained an injury on 5/31/2011. The mechanism of the injury was not specified in the records provided. The current diagnosis is cervical spondylosis without myelopathy. The patient experienced improvement on the right side of her neck and right arm following the right cervical root block at C6. The patient still complained of left sided neck pain. The patient also complained of pain in the low back, radiating down to the right leg with numbness and tingling in her toes. Physical examination revealed positive straight leg raising. An MRI of the cervical spine dated 9/11/2011 revealed degenerative changes at C5-6 with mild impingement of the thecal sac and no spinal cord compression. An EMG/NCV (electromyogram / nerve conduction velocity test) of the bilateral upper extremities is positive for mild carpal tunnel syndrome bilaterally. Six physical therapy visits were approved on 7/05/2012. The patient also had 2 physical therapy visits, which included massage therapy prior to 08/03/2012. An orthopedic report dated 4/18/2013 she was complaining of pain across the shoulders radiating down to the hand, mostly on the right side. Physical examination of the cervical spine noted she has increased tightness within the cervical spine and pain in the right side than left side. It does go into the trapezial area. She has a negative Spurling's and restricted range of motion. She has no specific numbness for tingling to the right or left side in any of the fingertip. She can feel everything. There is no focus neurologic deficit. She reportedly had an EMG nerve conduction study, which shows there to be C5-6 paraspinal nerve root irritation confirming it was a C6 problem. It was recommended that she have a C5-6 epidural and facet blocks, followed by physical therapy, as she reportedly has had no formal physical therapy to date. A clinic note dated 5/29/2013 noted the patient had pain on both sides of the neck with positive spurling sign on the right as well as on the left. The patient has altered sensation in the

thumb and index finger and in the long finger as well. She has some weakness with grip and wrist extensors of both sides to an equal degree. Impression C6 nerve root impingement, which is noted clinically and confirmed by MRI scan and electrodiagnostic study. A utilization- review, dated 07/05/13, reveals certification of a right cervical. ESI at CS-6 as well as 6 sessions of physical therapy (PT) and non-certification of right cervical facet block at C5-C6 due to contraindication with the requested ESI. A letter of certification dated 07/17/13 reveals certification of L4 and LS root blocks. An operative note, dated 07/26/13, reveals the patient underwent right C6 epidural. steroid injection in conjunction with bilateral CS-6 facet blocks. Each facet joint was injected with 2ml of injectate. A follow-up note, dated 08/14/13, the patient presented for follow-up and treating provider notes that he always performs epidural steroid injection with facet blocks. It was reported that overall the patient was about 50% better. The treating provider reports he has no problem with repeating the injection up to three times per year for the long term. The most recent evaluation, dated 09/25/13, is provided for review. The patient presented with complaints of neck and back pain. It was reported on this occasion that the patient received over 80% relief, but still has some pain on the left bothering her. It was recommended the patient undergo repeat epidural injection in conjunction with bilateral facet blocks. Physical examination was not performed, however, the treating provider indicates pain in the neck that goes down into her hand, positive impingement signs with extension and lateral rotation, without deficit of muscle strength, and radicular pattern of pain (not explained) more-on the left than the right this time.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral epidural steroid injections at C6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Complaints Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic) Chapter, Epidural Steroid Injection

Decision rationale: In the post procedure follow-up office visit dated 8/14/2013, the treating physician state: We focused on the right side at C6 and really had a tremendous improvement in the right-sided pain with the epidural The left side is still tight but there is no radiculopathy on the left side, while the radiculopathy on the right arm is clearly improved. The pain in the neck on the right side responded better than the left side, but that is much better. Overall, the pain is probably about 50% better. Whereas the right side really has responded very nicely to this injection, the left side is still rather tight and in some amount of pain." The guidelines stipulates that 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. 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.

The request for bilateral epidural steroid injections at C6 is not medically necessary or appropriate.

Bilateral facet block injections at C6 with fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Complaints Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic) Chapter, Epidural Steroid Injection

Decision rationale: The request for bilateral facet block injections at C6 with fluoroscopy, is not supported by the guidelines, which did not recommend this procedure. While not recommended, criteria for use of therapeutic intra-articular and medial branch blocks, if used anyway should meet the following criteria: 1. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 2. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 3. When performing therapeutic blocks, no more than 2 levels may be blocked at any one time. 4. If prolonged evidence of effectiveness is obtained after at least one therapeutic block, there should be consideration of performing a radiofrequency neurotomy. 5. There should be evidence of a formal plan of rehabilitation in addition to facet joint injection therapy. 6. No more than one therapeutic intra-articular block is recommended. The treating physician indicated that this patient has radiculopathy, and the guideline states that there should be no radicular pain. Also this patient has had previous facet block, according to the medical record reviewed in which the treating physician states that he does perform such a block as a matter of routine, and there is no documentation of how successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks) was. The request for bilateral facet block injections at C6 with fluoroscopy is not medically necessary or appropriate.

Post-injection physical therapy to cervical spine, twice per week for four weeks,: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary or appropriate.