

Case Number:	CM14-0154480		
Date Assigned:	09/24/2014	Date of Injury:	09/17/2009
Decision Date:	10/24/2014	UR Denial Date:	09/04/2014
Priority:	Standard	Application Received:	09/22/2014

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 Family Medicine 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 is a 49-year-old male patient who reported an industrial injury on 7/8/2005, over nine (9) years ago, to the right knee, neck, thoracic spine, and shoulders, attributed to the performance of his usual and customary job tasks as a fire captain. The patient reportedly hyperextended his right arm feeling a pinch to his neck. The patient has received substantial treatment to the cervical spine. The patient is diagnosed with cervical spine stenosis; cervical disc displacement; post laminectomy syndrome cervical spine; thoracic spondylosis. The patient also underwent a cervical spine disc replacement at C5-C6 and C6-C7 on 1/24/2013. The patient has had a prior cervical transforaminal epidural block at left C5 and an intra-articular facet block at right C7-T1 and intra-articular facet block at right C6-C7 on 5/14/2013. The cervical pain had been decreasing but was still a dull ache that radiated to the bilateral shoulders. The objective findings on examination demonstrated upper extremity neurological status was intact; tenderness at the costal vertebral and costotransverse joint region in the upper thoracic spine from T1 through T4 with 30% restriction in cervical rotation. The patient was noted to have a CT scan dated 5/13/2014 which demonstrated the hardware to be appropriately placed; no evidence of any recurrent a residual central or foraminal stenosis; artifact at the C5-C6 and C6-C7 levels. The cervical spine fusion was assessed as solid however he had persistent intermittent cervical pain. It was noted that the patient would like to try some injections for the cervical spine above and below the fusion, thus a plan was made to do C4-C5 on the left and on the right at C6-seven and C7-T1 if authorized.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right C4 selective nerve root blocks under fluoroscopic guidance: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 300,179-880,174-175,Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section neck and upper back chapter epidural steroid injections

Decision rationale: The request for the cervical spine transforaminal ESI or selective nerve root block is inconsistent with the recommendations of evidence-based guidelines, as the patient is not documented to have objective findings consistent with an acute nerve impingement radiculopathy. There are no recommendations for a cervical ESI as for degenerative disc disease. The MRI of the cervical spine does not demonstrate a nerve impingement radiculopathy. There is no electrodiagnostic evidence of a progressive radiculopathy. There are no documented neurological deficits that are progressive on physical examination. The patient was noted to have a prior transforaminal epidural steroid injection directed to C4, which was not documented to have led to any functional improvement. There was no objective evidence provided by the requesting provider to support the medical necessity of the requested cervical epidural injection for the treatment of chronic neck and UE pain or the stated subjective radiculopathy. There were no documented objective findings consistent with a radiculopathy on physical examination as the neurological status of the patient was intact. The patient was not reported to have documented specific neurological deficits over a dermatome distribution. The patient does not meet the criteria recommended by the CA MTUS for cervical ESIs as the treatment is directed to cervical spine for DDD s/p artificial disk replacement at two levels. The use of cervical ESIs for chronic cervical pain or for cervical spine DDD is not recommended by evidence-based guidelines. There is no impending surgical intervention being contemplated and the patient has requested conservative treatment. The patient is noted to be nine (9) years status post date of injury with the cited diagnoses of the cervical spine. The provider did not provide sufficient clinical documentation in the form of subjective/ objective findings on physical examination to support the medical necessity of the prescribed Cervical ESIs in relation to the reported industrial injury. The ACOEM Guidelines state that Cervical ESIs are of "uncertain benefit" and should be reserved for those patients attempting to avoid surgical intervention to the cervical spine. The Official Disability Guidelines state that there is insufficient evidence to treat cervical radiculopathy pain with ESIs. There is no objective evidence provided to support the medical necessity of the requested cervical ESI. The American Academy of Neurology states that there is insufficient objective evidence to recommend Cervical ESIs for the treatment of cervical radiculopathies. The CA MTUS and the Official Disability Guidelines recommend that a cervical radiculopathy must be documented by physical examination and corroborated by imaging studies and/or Electrodiagnostic testing in order to consider an ESI. The objective findings on physical examination did not demonstrate a cervical radiculopathy or any ongoing neurological deficits with any specificity over the global dermatological areas. There were no demonstrated neurological deficits, such as, sensory or motor loss over a dermatomal distribution. There was only documentation of a possible subjective radiculopathy to the RUE as there were no definite progressive neurological

deficits documented. The provided clinical documentation with the stated objective findings on physical examination do not meet the criteria recommended by the ACOEM Guidelines or the CA MTUS for the use of cervical ESIs. The documentation and objective evidence submitted does not meet the threshold recommended by the CA MTUS for the provision of a cervical ESI for the treatment of a cervical radiculopathy. The CA MTUS and the Official Disability Guidelines recommend that ESIs are utilized only in defined radiculopathies and a maximum of two cervical diagnostic ESIs and a limited number of therapeutic cervical ESIs are recommended in order for the patient to take advantage of the window of relief to establish an appropriate self-directed home exercise program for conditioning and strengthening. The criteria for a second diagnostic ESI is that the claimant obtain at least 30% relief from the prior appropriately placed ESI. The therapeutic cervical ESIs are only recommended, "If the patient obtains 50-70% pain relief for at least 6-8 weeks." Additional blocks may be required; however, the consensus recommendation is for no more than four (4) blocks per region per year. The indications for repeat blocks include "acute exacerbations of pain or new onset of symptoms." Although epidural injection of steroids may afford short-term improvement in the pain and sensory deficits in patients with radiculopathy due to herniated nucleus pulposus, this treatment, per the guidelines, seems to offer no significant long-term functional benefit, and the number of injections should be limited to two, and only as an option for short term relief of radicular pain after failure of conservative treatment and as a means of avoiding surgery and facilitating return to activity. The provided clinical evidence from the literature all suggests that ESIs are alternatives for surgical intervention and for the treatment of lumbar radiculopathy. They all agree that the beneficial results are transitory and short-term. None of the cases provided in literature listings addresses the long-term continued use of this treatment modality when radicular signs are unsupported by clinical imaging or Electrodiagnostic studies. There is no demonstrated medical necessity for the requested cervical spine transforaminal ESI or selective nerve block at right C4.

Left C4 selective nerve root blocks under fluoroscopic guidance: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 300,179-880,174-175,Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: The request for the cervical spine transforaminal ESI or selective nerve root block is inconsistent with the recommendations of evidence-based guidelines, as the patient is not documented to have objective findings consistent with an acute nerve impingement radiculopathy. There are no recommendations for a cervical ESI as for degenerative disc disease. The MRI of the cervical spine does not demonstrate a nerve impingement radiculopathy. There is no Electrodiagnostic evidence of a progressive radiculopathy. There are no documented neurological deficits that are progressive on physical examination. The patient was noted to have a prior transforaminal epidural steroid injection directed to C4, which was not documented to have led to any functional improvement. There was no objective evidence provided by the requesting provider to support the medical necessity of the requested cervical epidural injection for the treatment of chronic neck and UE pain or the stated subjective radiculopathy. There were no documented objective findings consistent with a radiculopathy on physical examination as the neurological status of the patient was intact. The patient was not reported to have documented

specific neurological deficits over a dermatome distribution. The patient does not meet the criteria recommended by the CA MTUS for cervical ESIs as the treatment is directed to cervical spine for DDD s/p artificial disk replacement at two levels. The use of cervical ESIs for chronic cervical pain or for cervical spine DDD is not recommended by evidence-based guidelines. There is no impending surgical intervention being contemplated and the patient has requested conservative treatment. The patient is noted to be nine (9) years status post date of injury with the cited diagnoses of the cervical spine. The provider did not provide sufficient clinical documentation in the form of subjective/ objective findings on physical examination to support the medical necessity of the prescribed Cervical ESIs in relation to the reported industrial injury. The ACOEM Guidelines state that Cervical ESIs are of "uncertain benefit" and should be reserved for those patients attempting to avoid surgical intervention to the cervical spine. The Official Disability Guidelines state that there is insufficient evidence to treat cervical radiculopathy pain with ESIs. There is no objective evidence provided to support the medical necessity of the requested cervical ESI. The American Academy of Neurology states that there is insufficient objective evidence to recommend Cervical ESIs for the treatment of cervical radiculopathies. The CA MTUS and the Official Disability Guidelines recommend that a cervical radiculopathy must be documented by physical examination and corroborated by imaging studies and/or Electrodiagnostic testing in order to consider an ESI. The objective findings on physical examination did not demonstrate a cervical radiculopathy or any ongoing neurological deficits with any specificity over the global dermatological areas. There were no demonstrated neurological deficits such as sensory or motor loss over a dermatomal distribution. There was only documentation of a possible subjective radiculopathy to the RUE as there were no definite progressive neurological deficits documented. The provided clinical documentation with the stated objective findings on physical examination do not meet the criteria recommended by the ACOEM Guidelines or the CA MTUS for the use of cervical ESIs. The documentation and objective evidence submitted does not meet the threshold recommended by the CA MTUS for the provision of a cervical ESI for the treatment of a cervical radiculopathy. The CA MTUS and the Official Disability Guidelines recommend that ESIs are utilized only in defined radiculopathies and a maximum of two cervical diagnostic ESIs and a limited number of therapeutic cervical ESIs are recommended in order for the patient to take advantage of the window of relief to establish an appropriate self-directed home exercise program for conditioning and strengthening. The criteria for a second diagnostic ESI is that the claimant obtain at least 30% relief from the prior appropriately placed ESI. The therapeutic cervical ESIs are only recommended, "If the patient obtains 50-70% pain relief for at least 6-8 weeks." Additional blocks may be required; however, the consensus recommendation is for no more than four (4) blocks per region per year. The indications for repeat blocks include "acute exacerbations of pain or new onset of symptoms." Although epidural injection of steroids may afford short-term improvement in the pain and sensory deficits in patients with radiculopathy due to herniated nucleus pulposus, this treatment, per the guidelines, seems to offer no significant long-term functional benefit, and the number of injections should be limited to two, and only as an option for short term relief of radicular pain after failure of conservative treatment and as a means of avoiding surgery and facilitating return to activity. The provided clinical evidence from the literature all suggests that ESIs are alternatives for surgical intervention and for the treatment of lumbar radiculopathy. They all agree that the beneficial results are transitory and short-term. None of the cases provided in literature listings addresses the long-term continued use of this treatment modality when radicular signs are unsupported by clinical imaging or Electrodiagnostic studies. There is no demonstrated medical necessity for the requested cervical spine transforaminal ESI or selective nerve block at left C4.

