

Case Number:	CM14-0025096		
Date Assigned:	06/11/2014	Date of Injury:	07/14/2004
Decision Date:	12/24/2014	UR Denial Date:	02/17/2014
Priority:	Standard	Application Received:	02/27/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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:

The patient 59-year-old female presenting with a work-related injury on July 14, 2004. On March 22, 2013 patient complained of persistent left shoulder pain. The patient is status post left shoulder surgery on August 19, 2011. The patient continued to complain of neck and bilateral shoulder as well as right hand pain. The patient had trigger point injections. The patient complained of restricted mobility in both shoulders that have been approved. The pain is also associated with pins and needles patient. The physical exam was taken for restricted range of motion all directions of the cervical spine; well healed scar; well healed arthroscopic scar over both shoulders; slight restricted range of motion in all 6 directions; Tinel's and Phalen's were positive bilaterally carpal tunnel area, worse on the right than the left; slightly decreased light touch and pinprick noted in the right hand which fortunately, director contradict the sensory path. CT scan from March 28, 2013 showed evidence of prior version from the fourth, mild canal stenosis with no cord compression and mild to moderate bilateral foraminal stenosis at C3 - C4 and to a lesser extent at C6 - C7. MRI of the cervical spine from July 23, 2012 showed facet hypertrophy bilaterally at C6 and C7 and C7 - T-1 as well as at C3 - C4. The provider recommended epidural steroid injection and cervical facet injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Epidural Steroid Injection under fluoroscopic guidance: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 47.

Decision rationale: Cervical Epidural Steroid Injection under Fluoroscopic Guidance is not medically necessary. The California MTUS page 47 states "the purpose of epidural steroid injections is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone is no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment, injections should be performed using fluoroscopy; if the ESI is for diagnostic purposes a maximum of 2 injections should be performed. No more than 2 nerve root levels should be injected using transforaminal blocks. No more than 1 interlaminar level should be injected at one session. 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 6-8 weeks, with the general recommendation of no more than 4 blocks per region per year. Current research does not support a series of 3 injections in either the diagnostic or therapeutic phase. We recommend no more than 2 epidural steroid injections." The physical exam is not consistent with cervical radiculitis. The cervical MRI does not demonstrate cervical nerve root compression corroborating cervical radiculitis. Additionally, there is lack of documentation of failed conservative therapy; therefore, the requested services are not medically necessary.

Cervical Facet Joint Injection under fluoroscopic guidance consisting of a left c2 medial branch nerve block and a left C2-3, C3-4, and C4-5 Facet Joint Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, criteria for the use of diagnostic blocks for facet nerve pain

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Extremity Complaints, Treatment Considerations

Decision rationale: Cervical Facet Joint Injection under fluoroscopic guidance consisting of a left c2 medial branch nerve block and a left c2-3, c3-4, and c4-5 facet joint injection is not medically necessary. The Occupation medicine practice guidelines criteria for use of diagnostic facet blocks require: that the clinical presentation be consistent with facet pain; Treatment is also limited to patients with cervical pain that is nonradicular and had no more than 2 levels bilaterally; documentation of failed conservative therapy including home exercise physical therapy and NSAID is required at least 4-6 weeks prior to the diagnostic facet block; no more than 2 facet joint levels are injected at one session; recommended by them of no more than 0.5 cc of injectate was given to each joint; no pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4-6 hours afterward; opioid should not be given as a

sedative during the procedure; the use of IV sedation (including other agents such as modafinil) may interfere with the result of the diagnostic block, and should only be given in cases of extreme anxiety; the patient should document pain relief with the management such as VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity level to support subjective reports of better pain control; diagnostic blocks should not be performed in patients in whom surgical procedures anticipated; diagnostic facet block should not be performed patients who have had a previous fusion procedure at the plan injection level. The physical exam does not clearly indicate cervical facet pain. The physical exam revealed a positive spurling's test which is indicative of radicular pain. Additionally, at least one segment is surgically fused. Cervical facet injections are not recommended at fused segments; therefore the requested procedure is not medically necessary.