

<b>Case Number:</b>	CM15-0144296		
<b>Date Assigned:</b>	08/05/2015	<b>Date of Injury:</b>	06/13/2012
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	07/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 injured worker is a 59-year-old female, who sustained an industrial injury on 6-13-12. She reported injury to her face, left knee, left shoulder and bilateral wrists related to a trip and fall accident. The injured worker was diagnosed as having cervical disc displacement without myelopathy, cervical spondylosis without myelopathy, carpal tunnel syndrome and post-concussion syndrome. Treatment to date has included a cervical and lumbar MRI on 7-8-14, an EMG-NCV on 7-7-15 showing mild to moderate right carpal tunnel syndrome and massage therapy. Current medications include Buprenorphine, Capsaicin, Gabapentin and Diclofenac cream. As of the PR2 dated 7-14-15, the injured worker reports continued neck and lower back pain that radiates to the right lower extremity. She rates her pain a 5 out of 10. Objective findings include a negative straight leg raise test and decreased cervical range of motion. The treating physician requested lumbar epidural steroid injection at L4-L5 and L5-S1 with epidurogram under fluoroscopic guidance with IV sedation, a cervical epidural steroid injection at C4-C5 and C5-C6 with epidurogram under fluoroscopic guidance with IV sedation, insertion of cervical catheter and Diclofenac cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar Epidural Steroid Injection at L4-L5 with epidurogram under fluoroscopic guidance with IV sedation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** The patient presents on 07/14/15 with lower back pain rated 5/10 which radiates into the bilateral buttocks and right lower extremity, and cervical spine pain rated 5/10 which radiates into the bilateral upper extremities. The patient's date of injury is 06/13/12. Patient has no documented surgical history directed at these complaints. The request is for LUMBAR EPIDURAL STEROID INJECTION AT L4-L5 WITH EPIDUROGRAM UNDER FLUOROSCOPIC GUIDANCE WITH IV SEDATION. The RFA is dated 07/17/15. Physical examination dated 07/14/15 reveals spasms and guarding in the lumbar spine with negative straight leg raise test noted bilaterally, tenderness to palpation of the cervical, lumbar, and thoracic paraspinal musculature with decreased range of motion noted in all planes. The patient is currently prescribed Buprenorphine, Capsaicin cream, Diclofenac cream, and Gabapentin. Diagnostic imaging included cervical MRI dated 07/08/14, significant findings include "small annular fissure at C4-5 which may contributed to pain via chemical mediators of inflammation. . .modest neural foraminal narrowing is depicted at C6-C7." A lumbar MRI dated 07/08/14 was also included, showing: "moderate discogenic change in the lumbar spine, small bulge at L4- L5. . . mild facet hypertrophy at L3-L4 and L4-L5. . . ventral anterior column osteophyte formation associated with edema at L1-L2." A diagnostic EMG/NCV of the upper extremities was also provided, significant findings include: "right medial palmar sensory and motor distal latencies were prolonged. The right medial antidromic SDL was prolonged. All over NCSs and NEMG study of the RUE were normal. . . the above findings are compatible with mild to moderate carpal tunnel syndrome." Patient is currently classified as permanent and stationary. MTUS Chronic Pain Treatment Guidelines, section on "Epidural steroid injections (ESIs)" page 46 states these are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." The MTUS Criteria for the use of Epidural steroid injections states: "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In this case, the provider is requesting what appears to be this patient's first lumbar ESI to date. Progress note dated 07/14/15 documents negative straight leg raise test bilaterally, with no evidence of decreased sensation along a specific dermatomal distribution in the lower extremities. MRI of the lumbar spine dated 07/08/14 does show some indication of moderate discogenic changes in the lumbar spine and the presence of a small bulge at L4-L5, though the extent to which this bulge impacts the exiting nerve roots is not clear. While this patient presents with significant chronic pain complaints unresolved by conservative measures, without unequivocal evidence of nerve root compromise or examination findings demonstrating compromise along a specific dermatomal distribution, the request for a lumbar ESI cannot be substantiated. The request IS NOT medically necessary.

**Lumbar Epidural Steroid Injection at L5-S1 with epidurogram under fluoroscopic guidance with IV sedation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** The patient presents on 07/14/15 with lower back pain rated 5/10, which radiates into the bilateral buttocks and right lower extremity, and cervical spine pain rated 5/10 which radiates into the bilateral upper extremities. The patient's date of injury is 06/13/12. Patient has no documented surgical history directed at these complaints. The request is for LUMBAR EPIDURAL STEROID INJECTION AT L4-L5 WITH EPIDUROGRAM UNDER FLUOROSCOPIC GUIDANCE WITH IV SEDATION. The RFA is dated 07/17/15. Physical examination dated 07/14/15 reveals spasms and guarding in the lumbar spine with negative straight leg raise test noted bilaterally, tenderness to palpation of the cervical, lumbar, and thoracic paraspinal musculature with decreased range of motion noted in all planes. The patient is currently prescribed Buprenorphine, Capsaicin cream, Diclofenac cream, and Gabapentin. Diagnostic imaging included cervical MRI dated 07/08/14, significant findings include "small annular fissure at C4-5 which may contributed to pain via chemical mediators of inflammation... modest neural foraminal narrowing is depicted at C6-C7." A lumbar MRI dated 07/08/14 was also included, showing: "moderate discogenic change in the lumbar spine, small bulge at L4-L5... mild facet hypertrophy at L3-L4 and L4-L5. . . ventral anterior column osteophyte formation associated with edema at L1-L2." A diagnostic EMG/NCV of the upper extremities was also provided, significant findings include: "right medial palmar sensory and motor distal latencies were prolonged. The right medial antidromic SDL was prolonged. All over NCSs and NEMG study of the RUE were normal. . . the above findings are compatible with mild to moderate carpal tunnel syndrome." Patient is currently classified as permanent and stationary. MTUS Chronic Pain Treatment Guidelines, section on "Epidural steroid injections (ESIs)" page 46 states these are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." The MTUS Criteria for the use of Epidural steroid injections states: "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In this case, the provider is requesting what appears to be this patient's first lumbar ESI to date. Progress note dated 07/14/15 documents negative straight leg raise test bilaterally, with no evidence of decreased sensation along a specific dermatomal distribution in the lower extremities. MRI of the lumbar spine dated 07/08/14 does show some indication of moderate discogenic changes in the lumbar spine and the presence of a small bulge at L4-L5, though the extent to which this bulge impacts the exiting nerve roots is not clear. While this patient presents with significant chronic pain complaints unresolved by conservative measures, without unequivocal evidence of nerve root compromise or examination findings demonstrating compromise along a specific dermatomal distribution, the request for a lumbar ESI cannot be substantiated. The request IS NOT medically necessary.

**Cervical Epidural Steroid Injection at C4-C5 with epidurogram under fluoroscopic guidance with IV sedation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46, 47.

**Decision rationale:** The patient presents on 07/14/15 with lower back pain rated 5/10, which radiates into the bilateral buttocks and right lower extremity, and cervical spine pain rated 5/10 which radiates into the bilateral upper extremities. The patient's date of injury is 06/13/12. Patient has no documented surgical history directed at these complaints. The request is for CERVICAL EPIDURAL STEROID INJECTION AT C4-C5 WITH EPIDUROGRAM UNDER FLUOROSCOPIC GUIDANCE WITH IV SEDATION. The RFA is dated 07/17/15. Physical examination dated 07/14/15 reveals spasms and guarding in the lumbar spine with negative straight leg raise test noted bilaterally, tenderness to palpation of the cervical, lumbar, and thoracic paraspinal musculature with decreased range of motion noted in all planes. The patient is currently prescribed Buprenorphine, Capsaicin cream, Diclofenac cream, and Gabapentin. Diagnostic imaging included cervical MRI dated 07/08/14, significant findings include: "small annular fissure at C4-5 which may contributed to pain via chemical mediators of inflammation... modest neural foraminal narrowing is depicted at C6-C7." A lumbar MRI dated 07/08/14 was also included, showing: "moderate discogenic change in the lumbar spine, small bulge at L4-L5... mild facet hypertrophy at L3-L4 and L4-L5. . . ventral anterior column osteophyte formation associated with edema at L1-L2." A diagnostic EMG/NCV of the upper extremities was also provided, significant findings include: "right medial palmar sensory and motor distal latencies were prolonged. The right medial antidromic SDL was prolonged. All over NCSs and NEMG study of the RUE were normal. . . the above findings are compatible with mild to moderate carpal tunnel syndrome." Patient is currently classified as permanent and stationary. MTUS has the following regarding ESIs, under its chronic pain section: Page 46, 47: "Criteria for the use of Epidural steroid injections: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3. Injections should be performed using fluoroscopy (live x-ray) for guidance. 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections." 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. MTUS states on p46, "there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain." In this case, the treater is requesting an initial cervical ESI targeted at the C4-5 level. Progress note dated 07/14/15 provides subjective reports of radicular pain, however the physical examination findings do not clarify whether the pain in the upper extremities originates in the cervical spine. This patient's MRI dated 03/06/15 does have some findings of foraminal narrowing in the cervical spine, though the provider does not document neurological compromise along a specific dermatomal distribution consistent with cervical stenosis. In addition, an upper extremity NCV/EMG dated 07/07/15 includes evidence of carpal tunnel syndrome, however, the remaining electrodiagnostic findings are unremarkable. While this patient presents with significant pain complaints unresolved by other interventions, without evidence of neurological compromise along a specific dermatomal distribution the request for a CESI cannot be substantiated. Furthermore, MTUS guidelines also state that there is insufficient evidence of the efficacy of cervical ESI to treat cervical radicular pain. Given the lack of unequivocal examination findings indicative of cervical radiculopathy, and the lack of firm guideline support for cervical ESI's directed at radicular pain, the request cannot be substantiated. Therefore, the request IS NOT medically necessary.

**Cervical Epidural Steroid Injection at C5-C6 with epidurogram under fluoroscopic guidance with IV sedation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid injection Page(s): 46, 47.

**Decision rationale:** The patient presents on 07/14/15 with lower back pain rated 5/10, which radiates into the bilateral buttocks and right lower extremity, and cervical spine pain rated 5/10 which radiates into the bilateral upper extremities. The patient's date of injury is 06/13/12. Patient has no documented surgical history directed at these complaints. The request is for CERVICAL EPIDURAL STEROID INJECTION AT C5-C6 WITH EPIDUROGRAM UNDER FLUOROSCOPIC GUIDANCE WITH IV SEDATION. The RFA is dated 07/17/15. Physical examination dated 07/14/15 reveals spasms and guarding in the lumbar spine with negative straight leg raise test noted bilaterally, tenderness to palpation of the cervical, lumbar, and thoracic paraspinal musculature with decreased range of motion noted in all planes. The patient is currently prescribed Buprenorphine, Capsaicin cream, Dicofenac cream, and Gabapentin. Diagnostic imaging included cervical MRI dated 07/08/14, significant findings include: "small annular fissure at C4-5 which may contributed to pain via chemical mediators of inflammation... modest neural foraminal narrowing is depicted at C6-C7." A lumbar MRI dated 07/08/14 was also included, showing: "moderate discogenic change in the lumbar spine, small bulge at L4-L5... mild facet hypertrophy at L3-L4 and L4-L5. . . ventral anterior column osteophyte formation associated with edema at L1-L2." A diagnostic EMG/NCV of the upper extremities was also provided, significant findings include: "right medial palmar sensory and motor distal latencies were prolonged. The right medial antidromic SDL was prolonged. All over NCSs and NEMG study of the RUE were normal. . . the above findings are compatible with mild to moderate carpal tunnel syndrome." Patient is currently classified as permanent and stationary. MTUS has the following regarding ESIs, under its chronic pain section: Page 46, 47: "Criteria for the use of Epidural steroid injections: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3. Injections should be performed using fluoroscopy (live x-ray) for guidance. 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections." 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. MTUS states on p46, "there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain." In this case, the treater is requesting an initial cervical ESI targeted at the C4-5 level. Progress note dated 07/14/15 provides subjective reports of radicular pain, however the physical examination findings to not clarify whether the pain in the upper extremities originates in the cervical spine. This patient's MRI dated 03/06/15 does have some findings of foraminal narrowing in the cervical spine, though the provider does not document neurological compromise along a specific dermatomal distribution consistent with cervical stenosis. In addition, an upper extremity NCV/EMG dated 07/07/15 includes evidence of carpal tunnel syndrome, however, the remaining electrodiagnostic findings are unremarkable. While this patient presents with significant pain complaints unresolved by other interventions, without evidence of neurological compromise along a specific dermatomal distribution the

request for a CESI cannot be substantiated. Furthermore, MTUS guidelines also state that there is insufficient evidence of the efficacy of cervical ESI to treat cervical radicular pain. Given the lack of unequivocal examination findings indicative of cervical radiculopathy, and the lack of firm guideline support for cervical ESI's directed at radicular pain, the request cannot be substantiated. Therefore, the request IS NOT medically necessary.

**Insertion of cervical catheter:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid injection Page(s): 46, 47.

**Decision rationale:** The patient presents on 07/14/15 with lower back pain rated 5/10, which radiates into the bilateral buttocks and right lower extremity, and cervical spine pain rated 5/10 which radiates into the bilateral upper extremities. The patient's date of injury is 06/13/12. Patient has no documented surgical history directed at these complaints. The request is for INSERTION OF CERVICAL CATHETER. The RFA is dated 07/17/15. Physical examination dated 07/14/15 reveals spasms and guarding in the lumbar spine with negative straight leg raise test noted bilaterally, tenderness to palpation of the cervical, lumbar, and thoracic paraspinal musculature with decreased range of motion noted in all planes. The patient is currently prescribed Buprenorphine, Capsaicin cream, Dicofenac cream, and Gabapentin. Diagnostic imaging included cervical MRI dated 07/08/14, significant findings include: "small annular fissure at C4-5 which may contributed to pain via chemical mediators of inflammation. . . modest neural foraminal narrowing is depicted at C6-C7. " A lumbar MRI dated 07/08/14 was also included, showing: "moderate discogenic change in the lumbar spine, small bulge at L4-L5... mild facet hypertrophy at L3-L4 and L4-L5. . . ventral anterior column osteophyte formation associated with edema at L1-L2." A diagnostic EMG/NCV of the upper extremities was also provided, significant findings include: "right medial palmar sensory and motor distal latencies were prolonged. The right medial antidromic SDL was prolonged. All over NCSs and NEMG study of the RUE were normal. . . the above findings are compatible with mild to moderate carpal tunnel syndrome." Patient is currently classified as permanent and stationary. MTUS has the following regarding ESIs, under its chronic pain section: Page 46, 47: "Criteria for the use of Epidural steroid injections: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3. Injections should be performed using fluoroscopy (live x-ray) for guidance. 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. " 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. MTUS states on p46, "there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain." In this case, the treater is requesting catheter placement for an initial cervical ESI targeted at the C4-5 level. Progress note dated 07/14/15 provides subjective reports of radicular pain, however the physical examination findings do not clarify whether the pain in the upper extremities originates in the cervical spine. This patient's MRI dated 03/06/15 does have some findings of foraminal narrowing in the cervical spine, though the provider does not document neurological compromise along a specific dermatomal distribution consistent with cervical stenosis. In addition, an upper extremity NCV/EMG dated 07/07/15 includes evidence of carpal tunnel syndrome; however, the remaining

electrodiagnostic findings are unremarkable. While this patient presents with significant pain complaints unresolved by other interventions, without evidence of neurological compromise along a specific dermatomal distribution the request for a CESI cannot be substantiated. Furthermore, MTUS guidelines also state that there is insufficient evidence of the efficacy of cervical ESI to treat cervical radicular pain. Given the lack of unequivocal examination findings indicative of cervical radiculopathy, and the lack of firm guideline support for cervical ESI's directed at radicular pain, the request cannot be substantiated. Therefore, the request IS NOT medically necessary.

**Topical Diclofenac sodium cream, QTY: 1: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical creams Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111.

**Decision rationale:** The patient presents on 07/14/15 with lower back pain rated 5/10, which radiates into the bilateral buttocks and right lower extremity, and cervical spine pain rated 5/10, which radiates into the bilateral upper extremities. The patient's date of injury is 06/13/12. Patient has no documented surgical history directed at these complaints. The request is for TOPICAL DICLOFENAC SODIUM CREAM QTY: 1. The RFA is dated 07/17/15. Physical examination dated 07/14/15 reveals spasms and guarding in the lumbar spine with negative straight leg raise test noted bilaterally, tenderness to palpation of the cervical, lumbar, and thoracic paraspinal musculature with decreased range of motion noted in all planes. The patient is currently prescribed Buprenorphine, Capsaicin cream, Diclofenac cream, and Gabapentin. Diagnostic imaging included cervical MRI dated 07/08/14, significant findings include: "small annular fissure at C4-5 which may contributed to pain via chemical mediators of inflammation... modest neural foraminal narrowing is depicted at C6-C7." A lumbar MRI dated 07/08/14 was also included, showing: "moderate discogenic change in the lumbar spine, small bulge at L4- L5. . . mild facet hypertrophy at L3-L4 and L4-L5. . . ventral anterior column osteophyte formation associated with edema at L1-L2." A diagnostic EMG/NCV of the upper extremities was also provided, significant findings include: "right medial palmar sensory and motor distal latencies were prolonged. The right medial antidromic SDL was prolonged. All over NCSs and NEMG study of the RUE were normal. . . the above findings are compatible with mild to moderate carpal tunnel syndrome." Patient is currently classified as permanent and stationary. The MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Recommended as an option as indicated below. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period... Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. "In regard to the continuation of topical Diclofenac for this patient's chronic lower back and cervical spine pain, this medication is not supported for this patient's chief complaint. The requesting provider documents chronic pain in the lower back which radiates into the lower extremities and cervical spine pain which radiates into the upper extremities. Guidelines do not support the use of topical NSAIDs such as Voltaren gel for spine, hip, or shoulder pain; as they are only supported for peripheral joint arthritis and tendinitis. Without a clearer indication as to where this medication is to be applied,

or evidence of the presence of peripheral joint complaints amenable to topical NSAIDs, use of this medication cannot be substantiated. Therefore, the request IS NOT medically necessary.