

Case Number:	CM15-0160215		
Date Assigned:	08/26/2015	Date of Injury:	01/17/2002
Decision Date:	10/02/2015	UR Denial Date:	07/31/2015
Priority:	Standard	Application Received:	08/17/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 70-year-old female who sustained an industrial injury on 01-17-2002. The injured worker was diagnosed with cervical facet arthropathy, cervicogenic headaches, upper extremity radiculopathy, thoracic and lumbar sprain and strain syndrome and depression. The injured worker has a history of gastric perforation. The injured worker is status post cervical anterior fusion at C4-C5, C5-C6 and C6-C7 in 2010, lumbar spinal cord stimulator (SCS) implant in April 2012 and radiofrequency thermocoagulation procedures of the median branch nerves of the cervical and lumbar regions. Treatment to date has included diagnostic testing, cervical fusion surgery, psychological evaluations, lumbar and cervical epidural steroid injection, lumbar spinal cord stimulator (SCS) implant, and cervical and lumbar radiofrequency thermocoagulation of the median branch nerves, acupuncture therapy, chiropractic therapy, physical therapy, home exercise program and medications. According to the primary treating physician's progress report on July 15, 2015, the injured worker continues to experience neck pain radiating to the left scapular area with numbness and tingling into the left upper extremity. Examination of the cervical spine demonstrated tenderness to palpation to the posterior cervical musculature with increased rigidity. Numerous trigger points were palpable and tender throughout the cervical paraspinal muscles. There was guarding and decreased range of motion noted as flexion, extension and bilateral lateral bending at 30 degrees each and bilateral lateral rotation at 60 each. Deep tendon reflexes and motor strength were intact bilaterally. Sensation to Wartenberg pinprick wheel was decreased along the lateral arm and forearm approximately in the C5-6 distribution bilaterally. Current medications were listed as Norco 10mg-325mg, Ultram

ER, Fexmid, Trazodone, Valium, Anaprox DS, Ambien, Brintellix and Prilosec. The injured worker received cervical trigger point injections times 4 at the office visit with 50% relief and increased range of motion within a few minutes later. Treatment plan consists of Electro-myography (EMG), continuing with medication regimen and the current request for one left C6-7 epidural steroid injection with fluoroscopy, cervical spinal cord stimulator (SCS) trial and cervical musculature trigger point injections times four.

IMR ISSUES, DECISIONS AND RATIONALES

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

One left C6-7 fluoroscopically guided catheter directed cervical epidural steroid injection:
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 Injections Page(s): 46.

Decision rationale: Per the MTUS CPMTG epidural steroid injections are used 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 offers no significant long-term benefit. The criteria for the use of epidural steroid injections are as follows: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) 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. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 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. The documentation submitted for review noted dermatomal sensory disturbance in approximately the C5-C6 pattern in the bilateral upper extremities and normal reflex and motor testing. MRI of the cervical spine dated 5/12/09 revealed moderate neural foraminal narrowing on the left at C6-C7. Above-mentioned citation conveys radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Radiculopathy is defined as two of the following: weakness, sensation deficit, or diminished/absent reflexes associated with the relevant dermatome. These findings are not documented, so medical necessity is not affirmed. As the first criteria is not met, the request is not medically necessary.

One cervical spinal cord stimulator trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable Spinal Cord Stimulators.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators Page(s): 105-106.

Decision rationale: With regard to spinal cord stimulators, the MTUS CPMTG states: "Recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions indicated below, and following a successful temporary trial". Indications for stimulator implantation: Failed back syndrome (persistent pain in patients who have undergone at least one previous back operation), more helpful for lower extremity than low back pain, although both stand to benefit, 40-60% success rate 5 years after surgery. It works best for neuropathic pain. Neurostimulation is generally considered to be ineffective in treating nociceptive pain. The procedure should be employed with more caution in the cervical region than in the thoracic or lumbar. Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD), 70-90% success rate, at 14 to 41 months after surgery. (Note: This is a controversial diagnosis.) Post amputation pain (phantom limb pain), 68% success rate, Post herpetic neuralgia, 90% success rate, Spinal cord injury dyesthesias (pain in lower extremities associated with spinal cord injury), Pain associated with multiple sclerosis, Peripheral vascular disease (insufficient blood flow to the lower extremity, causing pain and placing it at risk for amputation), 80% success at avoiding the need for amputation when the initial implant trial was successful. The data is also very strong for angina. (Flotte, 2004) Per the medical records, it was stated that the injured worker was a good candidate for cervical spinal cord stimulator trial. However, it was stated that the injured worker did not wish to pursue this treatment. As such, the request is not medically necessary.

Four (4) cervical musculature trigger point injections for a total of 10cc of 0.25% bupivacaine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: With regard to trigger point injections, the MTUS CPMTG states: "Recommended only for myofascial pain syndrome as indicated below, with limited lasting value." "Criteria for the use of Trigger point injections: Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam,

imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended." (Colorado, 2002) (BlueCross BlueShield, 2004) The medical records submitted for review indicate that the injured worker was previously treated with a set of 4 trigger point injections on 6/11/15, however there was no documentation of 50% pain relief for six weeks. Absent such documentation, the request is not medically necessary.