

Case Number:	CM15-0203841		
Date Assigned:	10/20/2015	Date of Injury:	10/14/2014
Decision Date:	12/02/2015	UR Denial Date:	10/05/2015
Priority:	Standard	Application Received:	10/16/2015

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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

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 60-year-old female, who sustained an industrial injury on 10-14-2014. The injured worker was being treated for cervicgia. Medical records (6-23-2015, 7-29-2015) indicate ongoing neck and right upper extremity pain and daily headaches. The injured worker reported a 40-50% reduction in her neck pain and improvement in her right upper extremity numbness and tingling. The treating physician noted that the injured worker reported 1-2 headaches per with the occipital nerve block. Medical records (9-25-2015) indicate ongoing neck and right upper extremity pain and daily headaches. The injured worker reported improved pain and movement of the neck and improved pain, numbness, and tingling of the right upper extremity. The injured worker reported a 45% reduction of neck pain from the right C5-6 (cervical 5-6) selective nerve block performed on 6-10-2015. Medical records (9-25-2015) also indicate the injured worker's headaches improved after a diagnostic greater occipital nerve block, but the injection has worn off. The injured worker reported daily headaches and 20-25 headaches per month. The medical records show the subjective pain rating was 7 out of 10 without medications on a visual analog scale and 5 out of 10 with medications on 7-29-2015 and 9-25-2015. The physical exam (7-29-2015, 9-25-2015) reveals pain to touch over the nuchal ridge and occipital region, Tinel's over the great occipital nerve area and percussion over the area elicits pain, and pain over the right mastoid area and C1-2 (cervical 1-2) areas. There was mild cervical lordosis and straightening of the cervical spine with loss of normal cervical lordosis. There was restricted cervical range of motion, severe pain and stiffness at end ranges of motion, and tenderness, spasm, and hypertonicity of the bilateral paravertebral muscles. There were pain in

the neck muscles with Spurling's maneuver and a positive right foraminal compression test with pain radiating down the right arm. The MRI of the cervical spine dated 3-4-2015 stated that there was mild chronic loss of vertebral body height at the mid and lower cervical levels with reversal of normal lordosis at C5 (cervical 5), causing flattening of the ventral surface of the spinal cord without obvious compression or central canal stenosis. There is moderate right foraminal narrowing at C5-6 and mild foraminal narrowing at C3-4, C5-6, and C6-7. Treatment has included physical therapy, acupuncture, a home exercise program, work restrictions, and medications including Topamax (since at least 9-2015), Nortriptyline, Excedrin, Omeprazole, Naproxen, and Mobic. Per the treating physician (9-25-2015 report), the injured worker continues to work with restrictions. The requested treatments included cervical facet injections bilaterally at C1-2, a left greater occipital nerve block under fluoroscopy, and request for Topamax 100mg. On 10-5-2015, the original utilization review non-certified requests for cervical facet injections bilaterally at C1-2 and a left greater occipital nerve block under fluoroscopy and a retrospective request for Topamax 100mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical facet injections bilaterally at C1-2: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Epidural steroid injections (ESIs).

Decision rationale: MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)...Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." There were no medical documentation provided to conclude that other rehab efforts ongoing. Additionally, no objective findings were documented to specify the dermatomal distribution of pain. MTUS further defines the criteria for epidural steroid injections to include: 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 medical documents provided document a negative spurling test and upper extremity motor, sensory and reflex physical examinations were all normal. Concerning medical imaging, there is no evidence of cervical nerve root compression on MRI. The medical documents provided do not provide evidence of cervical radiculopathy and the guidelines recommend blocks from C3-C7. As such, the request for Cervical facet injections bilaterally at C1-2 is deemed not medically necessary.

Left greater occipital nerve block under fluoroscopy: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head, Greater occipital nerve block (GONB).

Decision rationale: ODG states regarding occipital blocks; Under study for use in treatment of primary headaches. Studies on the use of greater occipital nerve block (GONB) for treatment of migraine and cluster headaches show conflicting results, and when positive, have found response limited to a short-term duration. (Ashkenazi, 2005) (Inan, 2001) (Vincent, 1998) (Afridi, 2006) The mechanism of action is not understood, nor is there a standardized method of the use of this modality for treatment of primary headaches. A recent study has shown that GONB is not effective for treatment of chronic tension headache. (Leinisch, 2005) The block may have a role in differentiating between cervicogenic headaches, migraine headaches, and tension-headaches. The available medical record does not provide an adequate description of symptomology that would define a diagnosis of occipital neuralgia in this IW. Given the conflicting results of studies and lack of clear indication in this IW the request for Left greater occipital nerve block under fluoroscopy is deemed not medically necessary.

Retrospective request for Topamax 100mg #30 with one refill (DOS: 9/25/15): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Topamax is the brand name version of Topiramate, which is an anti-epileptic medication. MTUS states that anti-epilepsy drugs are recommended for neuropathic pain, but do specify with caveats by medication. MTUS states regarding Topamax, "has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. Topiramate has recently been investigated as an adjunct treatment for obesity, but the side effect profile limits its use in this regard." The available medical record does not indicate the failure of other first line anticonvulsants, such as gabapentin. As such, the request for Topamax 100mg #30 with 1 refill is deemed not medically necessary.