

<b>Case Number:</b>	CM15-0090357		
<b>Date Assigned:</b>	05/14/2015	<b>Date of Injury:</b>	06/15/2000
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	04/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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 58 year old female, who sustained an industrial injury on 06/15/2000. She has reported subsequent neck, left shoulder and left upper extremity pain and was diagnosed with cervical spondylosis, left sided cervical facet pain, left cervical radiculopathy, left shoulder impingement and left acromioclavicular joint arthropathy. Treatment to date has included oral pain medication, physical therapy and a home exercise program. In a progress note dated 04/03/2015, the injured worker complained of bilateral neck, bilateral shoulder and bilateral low back pain. Objective findings were notable for severe tenderness of the left lumbar facets of L4-L5 and L5-S1 with severe muscle spasm, mild tenderness of the right lumbar facets of L4-L5 and L5-S1, moderate muscle spasm and tenderness of the left cervical facets at C4-C5, C5-C6, C6-C7 and C7-T1 and trapezial muscle spasm, moderate to severely tender trigger points, moderate tenderness of the left shoulder and positive Hawkins and impingement tests. A request for authorization of transforaminal epidural steroid injection of left C5-C6 and C6-C7, diagnostic facet injection of left L4-L5 and L5-S1 and MRI of the lumbosacral spine was submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transforaminal epidural steroid injection left C5-C6, C6-7: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47.

**Decision rationale:** The patient presents with bilateral neck pain and severe LEFT shoulder pain alternating with right shoulder pain. LEFT side is much worse. Patient also complaining of thoracic pain and bilateral low back pain without any radiation into the lower extremities. The request is for Transforaminal Epidural Steroid Injection Left C5-C6, C6-C7. The request for authorization is dated 04/03/15. MRI of the cervical spine, 06/23/14, shows moderate spondylitic changes most prominent at C5-6, C6-7 and C7-T1. At C5-6: moderate disc desiccation; mild to moderate diffuse disc bulge, reactive bone marrow changes and Schmorl's nodes; moderate central spinal canal narrowing; bilateral neural foraminal disc protrusion and osteophyte complex. At C6-7: moderate disc desiccation, moderate central canal narrowing; moderate spinal and neural foraminal narrowing. EMG/NCS of the LEFT upper extremity, 09/09/14, shows normal EMG without evidence of acute or chronic denervation. Normal NCS without evidence of generalized peripheral neuropathy, or focal or compression neuropathy. Physical examination of the lumbar spine reveals severe tenderness over the LEFT lumbar facets, L4-5 and L5-S1 with severe muscle spasm and only mild tenderness over the right lumbar facets, L4-5 and L5-S1 without any significant muscle spasm. Facet joint provocation is strongly positive on the LEFT and mildly positive on the right. Faber test, SLR, Lasegue's test are negative bilaterally. No sensory motor deficits in the lower extremity. Exam of the cervical spine reveals moderate muscle spasm and tenderness overlying the LEFT cervical facets C4-5, C5-6, C6-7 and C7-T1 and also trapezial muscle spasm, which is moderate to severely tender trigger points. The patient also exhibits LEFT-sided suboccipital tenderness in the trapezius and longissimus: Muscle aponeurosis. Without axial loading cervical rotation and extension was painful only on the LEFT side. Spurling's is negative except causing pain on the LEFT neck and cervicothoracic region. There was no tingling, numbness going into the extremity with the test. There was no sensory deficit in the upper extremities, but motor deficits are seen secondary to pain and disuse of the left hand and elbow. Exam of the LEFT shoulder reveals moderate tenderness over the acromioclavicular joint, severe tenderness over the anterior acromion, and moderate tenderness over the biceps tendon. She had a positive speed, Hawkins and impingement tests. She gives a pain score of 9/10 and describes the pain as sharp with difficulty in rotation of the left side and movement of the LEFT shoulder, which is very painful. She also has a lot of trouble rotating her lumbar spine. Bending forwards and backwards causes a lot more pain. The low back pain is more on the LEFT than the right side. The patient has had physical therapy twice for cervical spine and shoulders. She has been on a home exercise program, but states that she is continuing to get worse over time. Patient's medications include Fenoprofen, Omeprazole, Cyclobenzaprine, Amitriptyline, Theramine and Trepadone. Per progress report dated 04/03/15, the patient is temporarily totally disabled. MTUS page 46, 47 states that an ESI is Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). MTUS further states: Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. 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." Per progress report dated 04/03/15, treater's reason for the request is "the patient's pain in the left shoulder and cervicothoracic region is a combination of cervical radiculopathy and left shoulder impingement." In this case, MRI of the cervical spine shows moderate spondylitic changes most prominent at C5-6, C6-7 and C7-T1. At C5-6: moderate disc desiccation; mild to moderate diffuse disc bulge, reactive bone marrow changes and Schmorl's nodes; moderate central spinal canal narrowing; bilateral neural foraminal disc protrusion and osteophyte complex. At C6-7: moderate disc desiccation, moderate central canal narrowing; moderate spinal and neural foraminal narrowing. However, physical examination of the cervical spine reveals Spurling's is negative except causing pain on the LEFT neck and cervicothoracic region. There was no tingling, numbness going into the extremity with the test. There was no sensory deficit in the upper extremities, but motor deficits are seen secondary to pain and disuse of the left hand and elbow. Radiculopathy is not documented by physical examination and corroborated by imaging studies. Therefore, the request is not medically necessary.

### **Diagnostic facet Left L4-5 and L5-S1: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Facet joint diagnostic blocks (injections).

**Decision rationale:** The patient presents with bilateral neck pain and severe LEFT shoulder pain alternating with right shoulder pain. LEFT side is much worse. Patient also complaining of thoracic pain and bilateral low back pain without any radiation into the lower extremities. The request is for Diagnostic Facet Left L4-5 AND L5-S1. The request for authorization is dated 04/03/15. MRI of the cervical spine, 06/23/14, shows moderate spondylitic changes most prominent at C5-6, C6-7 and C7-T1. At C5-6: moderate disc desiccation; mild to moderate diffuse disc bulge, reactive bone marrow changes and Schmorl's nodes; moderate central spinal canal narrowing; bilateral neural foraminal disc protrusion and osteophyte complex. At C6-7: moderate disc desiccation, moderate central canal narrowing; moderate spinal and neural foraminal narrowing. EMG/NCS of the LEFT upper extremity, 09/09/14, shows normal EMG without evidence of acute or chronic denervation. Normal NCS without evidence of generalized peripheral neuropathy, or focal or compression neuropathy. Physical examination of the lumbar spine reveals severe tenderness over the LEFT lumbar facets, L4-5 and L5-S1 with severe muscle spasm and only mild tenderness over the right lumbar facets, L4-5 and L5-S1 without any significant muscle spasm. Facet joint provocation is strongly positive on the LEFT and mildly positive on the right. Faber test, SLR, Lasegue's test is negative bilaterally. No sensory motor deficits in the lower extremity. Exam of the cervical spine reveals moderate muscle spasm and tenderness overlying the LEFT cervical facets C4-5, C5-6, C6-7 and C7-T1 and also trapezial muscle spasm, which is moderate to severely tender trigger points. The patient also exhibits LEFT-sided suboccipital tenderness in the trapezius and longissimus: Muscle aponeurosis. Without axial loading cervical rotation and extension was painful only on the

LEFT side. Spurling's is negative except causing pain on the LEFT neck and cervicothoracic region. There was no tingling, numbness going into the extremity with the test. There was no sensory deficit in the upper extremities, but motor deficits are seen secondary to pain and disuse of the left hand and elbow. Exam of the LEFT shoulder reveals moderate tenderness over the acromioclavicular joint, severe tenderness over the anterior acromion, and moderate tenderness over the biceps tendon. She had a positive speed, Hawkins and impingement tests. She gives a pain score of 9/10 and describes the pain as sharp with difficulty in rotation of the left side and movement of the LEFT shoulder, which is very painful. She also has a lot of trouble rotating her lumbar spine. Bending forwards and backwards causes a lot more pain. The low back pain is more on the LEFT than the right side. The patient has had physical therapy twice for cervical spine and shoulders. She has been on a home exercise program, but states that she is continuing to get worse over time. Patient's medications include Fenopufen, Omeprazole, Cyclobenzaprine, Amitriptyline, Theramine and Trepadone. Per progress report dated 04/03/15, the patient is temporarily totally disabled. ODG Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Facet joint diagnostic blocks (injections) Section states: For Facet joint diagnostic blocks for both facet joint and Dorsal Median Branches: Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. "There should be no evidence of radicular pain, spinal stenosis, or previous fusion," and "if successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive)." Per progress report dated 04/03/15, treater's reason for the request is "If efficacious, we'll proceed with confirmatory median branch block in order to accomplish radiofrequency rhizotomy." ODG guidelines limit blocks for patients with non-radicular low-back pain. In this case, the patient presents with pain in his low back without any radiation into the lower extremities. Physical examination of the lumbar spine reveals Faber test, SLR, Lasegue's test are negative bilaterally. No sensory motor deficits in the lower extremity. Therefore, the request is medically necessary.

**MRI of lumbar sacral spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter, MRIs (magnetic resonance imaging).

**Decision rationale:** The patient presents with bilateral neck pain and severe LEFT shoulder pain alternating with right shoulder pain. LEFT side is much worse. Patient also complaining of thoracic pain and bilateral low back pain without any radiation into the lower extremities. The request is for MRI Of Lumbar Sacral Spine. The request for authorization is dated 04/03/15. MRI of the cervical spine, 06/23/14, shows moderate spondylitic changes most prominent at C5-6, C6-7 and C7-T1. At C5-6: moderate disc desiccation; mild to moderate diffuse disc bulge, reactive bone marrow changes and Schmorl's nodes; moderate central spinal canal narrowing; bilateral neural foraminal disc protrusion and osteophyte complex. At C6-7: moderate disc desiccation,

moderate central canal narrowing; moderate spinal and neural foraminal narrowing. EMG/NCS of the LEFT upper extremity, 09/09/14, shows normal EMG without evidence of acute or chronic denervation. Normal NCS without evidence of generalized peripheral neuropathy, or focal or compression neuropathy. Physical examination of the lumbar spine reveals severe tenderness over the LEFT lumbar facets, L4-5 and L5-S1 with severe muscle spasm and only mild tenderness over the right lumbar facets, L4-5 and L5-S1 without any significant muscle spasm. Facet joint provocation is strongly positive on the LEFT and mildly positive on the right. Faber test, SLR, Lasegue's test are negative bilaterally. No sensory motor deficits in the lower extremity. Exam of the cervical spine reveals moderate muscle spasm and tenderness overlying the LEFT cervical facets C4-5, C5-6, C6-7 and C7-T1 and also trapezial muscle spasm, which is moderate to severely tender trigger points. The patient also exhibits LEFT-sided suboccipital tenderness in the trapezius and longissimus: Muscle aponeurosis. Without axial loading cervical rotation and extension was painful only on the LEFT side. Spurling's is negative except causing pain on the LEFT neck and cervicothoracic region. There was no tingling, numbness going into the extremity with the test. There was no sensory deficit in the upper extremities, but motor deficits are seen secondary to pain and disuse of the left hand and elbow. Exam of the LEFT shoulder reveals moderate tenderness over the acromioclavicular joint, severe tenderness over the anterior acromion, and moderate tenderness over the biceps tendon. She had a positive speed, Hawkins and impingement tests. She gives a pain score of 9/10 and describes the pain as sharp with difficulty in rotation of the left side and movement of the LEFT shoulder, which is very painful. She also has a lot of trouble rotating her lumbar spine. Bending forwards and backwards causes a lot more pain. The low back pain is more on the LEFT than the right side. The patient has had physical therapy twice for cervical spine and shoulders. She has been on a home exercise program, but states that she is continuing to get worse over time. Patient's medications include Fenopropfen, Omeprazole, Cyclobenzaprine, Amitriptyline, Theramine and Trepadone. Per progress report dated 04/03/15, the patient is temporarily totally disabled. ODG guidelines, Low back chapter, MRIs (magnetic resonance imaging) (L-spine) state that "for uncomplicated back pain MRIs are recommended for radiculopathy following at least one month of conservative treatment." ODG guidelines further state the following regarding MRI's, Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). Treater does not discuss this request. Review of medical records shows the patient has not previously had a MRI of the lumbar sacral spine. In this case, the patient continues with low back without any radiation into the lower extremities. Physical examination of the lumbar spine reveals Faber test, SLR, Lasegue's test are negative bilaterally. There are no red flags, no neurologic deficit and no radicular symptoms for which an MRI would be indicated. No sensory motor deficits in the lower extremity. Therefore, the request is not medically necessary.