

Case Number:	CM14-0111154		
Date Assigned:	08/01/2014	Date of Injury:	09/30/2012
Decision Date:	10/03/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/16/2014

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 California. 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:

According to the records made available for review, this is a 37-year-old female with a 9/30/12 date of injury. At the time (6/9/14) of the request for authorization for pain management with ESI and medial branch block cervical spine, there is documentation of subjective (significant pain to her neck and left shoulder, as well as radiating pain down the left upper extremity) and objective (spasm about the left side of her neck, point tenderness upon palpation about the left side of her neck and the bilateral trapezial areas, left wrist extension (C6) and elbow extension (C7) 4/5 strength) findings, current diagnoses (cervical spine disc bulge at C5-6 and C6-7, with left-sided C6 and C7 radiculopathy; left shoulder frozen shoulder; and anxiety), and treatment to date (medication, acupuncture, and therapy). Regarding pain management with ESI, there is no documentation of imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels. Regarding medial branch block cervical spine, there is no documentation of cervical pain that is non-radicular and no more than 2 joint levels to be injected in one session.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain management with ESI: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections. Decision based on Non-MTUS Citation ACOEM Chapter 7, Consultation

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Epidural Steroid Injections (ESIs)

Decision rationale: The MTUS reference to ACOEM guidelines identifies cervical epidural corticosteroid injections should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, and failure of conservative treatment (activity modification, medications, and physical modalities), as criteria necessary to support the medical necessity of cervical epidural injection. ODG additionally identifies it is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. Within the medical information available for review, there is documentation of diagnoses of cervical spine disc bulge at C5-6 and C6-7, with left-sided C6 and C7 radiculopathy; left shoulder frozen shoulder; and anxiety. In addition, there is documentation of subjective (pain) and objective (motor changes) radicular findings in each of the requested nerve root distributions and failure of conservative treatment (activity modification, medications, and physical modalities). However, there is no documentation of imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels. In addition, given documentation of an associated request for medial branch block, there is no documentation that epidural blocks will not be performed on the same day of treatment as facet blocks. Therefore, based on guidelines and a review of the evidence, the request for pain management with ESI is not medically necessary.

Medial Branch Block cervical spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Facet joint diagnostic blocks

Decision rationale: The MTUS reference to ACOEM identifies documentation of non-radicular facet mediated pain as criteria necessary to support the medical necessity of medial branch block.

ODG identifies documentation of cervical pain that is non-radicular and at no more than two levels bilaterally, failure of conservative treatment (including home exercise, PT, and NSAIDs) prior to the procedure for at least 4-6 weeks, and no more than 2 joint levels to be injected in one session, as criteria necessary to support the medical necessity of facet injection. In addition, ODG identifies it is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. Within the medical information available for review, there is documentation of diagnoses of cervical spine disc bulge at C5-6 and C6-7, with left-sided C6 and C7 radiculopathy; left shoulder frozen shoulder; and anxiety. In addition, there is documentation of failure of conservative treatment (including home exercise, PT, and NSAIDs) prior to the procedure for at least 4-6 weeks. However, given documentation of radiating pain down the left upper extremity and elbow extension (C7) 4/5 strength, there is no documentation of cervical pain that is non-radicular. In addition, given the request for medial branch block cervical spine, there is no documentation of no more than 2 joint levels to be injected in one session. Furthermore, given documentation of an associated request for ESI, there is no documentation that facet blocks will not be performed on the same day of treatment as epidural steroid injections. Therefore, based on guidelines and a review of the evidence, the request for medial branch block cervical spine is not medically necessary.