Case Number:	CM14-0144265		
Date Assigned:	09/12/2014	**Date of Injury:**	08/08/2003
Decision Date:	10/10/2014	**UR Denial Date:**	08/08/2014
Priority:	Standard	**Application Received:**	09/05/2014

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 Neurology, has a subspecialty in Clinical Neurophysiology and is licensed to practice in Virginia. 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, the injured worker (IW) is a 57 year old female with a date of injury of 07 March, 2003. The mechanism of injury is a fall at work. She was standing on a box when she fell approximately 2 feet striking the side of her head and shoulder. There is an MRI of the Cervical (C) spine dated 11 April, 2003 which showed a slight loss of the cervical curvature. There are degenerative changes at C5-C6 with minimal spondylolisthesis and a broad disk osteophyte complex with mild spinal stenosis and moderate bilateral neuroforaminal narrowing (right>left). A clinical note dated 25 November, 2003 notes that she complains of neck and low back pain as well as bilateral arm pain. She has a documented Electromyography (EMG) testing dated 14 June 2006 which showed a moderate bilateral Carpal Tunnel Syndrome. This testing did not show evidence of a cervical radiculopathy. On 12 October, 2009, there is documentation that she had an anterior cervical fusion at the C5-C6 and C6-C7 levels. There is a clinical note dated 12 April, 2010 which showed that the injured worker continued to complain of neck pain, low back pain and headaches. She was diagnosed with vascular headaches at that time. A clinical note dated 25 March, 2011 documents that her headaches are due to a diagnosis of Occipital Neuralgia. There is a documented note dated 11 November, 2011 that she received an Occipital nerve block but with limited success. On 16 March, 2012, she had a follow up MRI C spine documented due to continuing neck pain which shows ongoing cervical compression at the C5-6 level. There is an anterior cervical fusion at C5-C6 and cervical fusion at the C5-C6 levels. There is obvious nonunion at the C5-C6 levels. She subsequently has a documented cervical spine surgery dated 17 May, 2012 with a partial corpectomy at the C5 and C6 levels and an anterior cervical fusion at the C5-C6 levels. On 27 January, 2014, the IW has a documented clinical encounter complaining of low back pain with an intensity of 8/10. There is documentation on this exam of

normal motor and reflex changes. There is a normal sensory testing except for decreased sensation in the left L5 and S1 dermatomes. Her gait is antalgic and the strait leg testing is positive on the left. She is subsequently treated with lumbar epidural steroid injections at the L4-L5 level on 18 July, 2014. A clinical note dated 07 August, 2014 that she has had severe headaches since the epidural steroid injections. A follow up clinical note dated 05 September, 2014 documents that her treating physician does not feel that these headaches are due to her epidural steroid injections but are rather due to shoulder pain. There is no documentation of positional changes to her headaches to suggest a pattern that worsens when she stands up and improves when lying down. A Clinical exam on 05 September 2014 documents normal strength and reflex exam, normal sensory exam except numbness on the left leg in an L5 and S1 distribution. Her gait is antalgic and the strait leg raise is positive on the left.

IMR ISSUES, DECISIONS AND RATIONALES

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

ASAP - Lumbar Blood Patch: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation J Neurosurg. 2014 Aug 1:1-7. Novel hydrogel application in minimally invasive surgical approaches to spontaneous intracranial hypotension. Chai CMI.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: 1. Up To Date. Post Lumbar Puncture Headaches. Sun-Edelstein C. et al. 2014 2. Silberstein SD et al. Headache associated with changes in intracranial pressure. Headache 1992, 32:84.

Decision rationale: Up To Date documents that patients undergoing a procedure involving a puncture at the dural sac are at risk for potential post lumbar headaches. It is documented that the clinical features of a post lumbar puncture headache characteristically present with a frontal or an occipital headache that occurs within 6-72 hours of the procedure. Also documented is that a unique clinical feature of a post lumbar puncture headache is that it is exacerbated while the patient is in an upright position and is improved while in the supine position. Without treatment, a post lumbar puncture headache typically lasts 2-15 days. Treatment for a post lumbar puncture headache involves conservative treatment with bed rest within the first 24 hours and analgesics. If patients fail initial conservative treatment, an epidural blood patch is considered the treatment of choice for patients with post lumbar puncture headaches. In the case of the injured worker, after a long treatment course for chronic neck pain, back pain, chronic headaches and right shoulder pain, she received an epidural steroid injection for relief of back pain at the L4-L5 level on 07 August, 2014. It is documented that her headaches worsened after the epidural steroid injections were given. There is no documentation of a trial of conservative treatment to manage her headaches. There is no documentation of a clinical presentation of headaches which worsen in the upright position and improve with lying down. Furthermore, it is documented on 05 September, 2014 that her treating physician believes that her headaches are not from the epidural steroid injections but are rather from her chronic shoulder pain. Therefore, based on the

guidelines and the review of the evidence, an ASAP Lumbar blood patch is not medically necessary.