

<b>Case Number:</b>	CM14-0214645		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	11/01/2010
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	11/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/22/2014

### 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. 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 patient is a 39-year-old female with a 11/01/2010 date of injury. 560 pages of mixed records from 2/19/14 through 10/28/14 are provided for review. Many of the individual records provided in the .pdf format are missing pages and not in numerical order. There is a partial report from 8/13/14 that requests bilateral occipital nerve injections, right ulnar nerve injection at the elbow, cervical epidural steroid injection. The 8/13/14 exam shows 2+ tenderness over the right occiput and 1+ tenderness at the left; cervical facet test is positive on the right; 2+ hyperaesthesia distal to the right elbow; sensation is intact in bilateral upper extremities; reflexes intact. 4/5 weakness in right lower extremity. The diagnoses include: cervicgia; occipital neuralgia; cervical radiculitis; herniated disc, cervical; spinal stenosis; right elbow arthropathy; right elbow derangement; right forearm pain; right elbow enthesiopathy; ulnar nerve injury. There is a partial orthopedic QME report dated 10/28/14 that states the patient did computer work since 2005 and had gradual onset of upper extremity pain. She underwent deQuervain's release in June 2011 and had persistent paresthesia since. Elbow injections for lateral epicondylitis helped in Oct. 2011. She underwent revision surgery of right deQuervain's in June 2012 and also a right lateral epicondylitis release. She developed neck and shoulder pain after the June 2012 elbow surgery. She has not returned to work since May 2013. The 10/28/14 QME report ends at page 8, in the middle of the physical exam reporting. On 11/24/14 utilization review assessed the 11/6/14 chiropractic note and 8/13/14 medical report and denied an occipital nerve block because there is no documented headache; denied a right "ulnar epidural steroid injection" because it was not

clear the request meant; and denied a cervical epidural steroid injection because there was no documented radiculopathy.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Bilateral occipital nerve injections: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Head Chapter, Greater occipital nerve block, diagnostic

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

**Decision rationale:** The provided records show that bilateral occipital nerve injections were requested in an 8/13/14 report, for palpable tenderness. Subsequently the patient was evaluated by a QME on 10/28/14, and the complaints at that time did not include occipital pain and there were no physical exam findings on the head, although only the first part of the QME report was provided for this review. ODG-TWC guidelines, Head chapter online for Greater occipital nerve block (GONB) states this is under study for treatment of 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 most recent reports do not mention subjective complaints of headache or provide evaluation to differentiate a headache. The ODG guidelines state occipital nerve blocks are under study and not effective for treatment of chronic tension headache. Based on the available information, the request for bilateral occipital nerve injections IS NOT medically necessary.

#### **Right ulnar epidural steroid injection at elbow: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 18-19, 31-32.

**Decision rationale:** The request for "Right ulnar epidural steroid injection at elbow" appears to be a typographical error. The 8/13/14 report shows the physician requested "right ulnar nerve injection at the elbow". The ulnar nerve is toward the medial epicondyle and typically involves paresthesia to the 4th and 5th digits. The current report states the patient's pain drawing shows paresthesia to the 1st-3rd digits, but there is medial epicondyle pain. There are available reporting states the patient had lateral epicondyle injections in the past that were effective and she currently does not have lateral epicondyle pain. There are no current reports that suggest ulnar nerve involvement. There are no electrodiagnostic studies available to support the

physician's request. ACOEM Practice Guidelines, 2nd Edition (Revised 2007), Chapter 10, page 31-32, for Medial Epicondylagia (Medial epicondylitis) states. Quality studies are available on glucocorticoid injections in chronic medial epicondylagia patients and there is evidence of short-term, but not long-term benefits. This option is invasive, but is low cost and has few side effects. Thus, glucocorticoid injections are recommended ACOEM Practice Guidelines, 2nd Edition (Revised 2007), Chapter 10, page 18-19, for Ulnar Nerve Entrapment (including Cubital Tunnel Syndrome) states Proper testing to localize the abnormality involves a nerve conduction study that includes at least stimulation above and below the elbow and Aside from surgical studies, there are no quality studies on which to rely for treatment of ulnar neuropathies, The reporting shows tenderness at the medial epicondyle and according to the ACOEM guidelines the patient may be a candidate for an injection for medial epicondylitis however, this request is for an ulnar nerve injection. There are no current records, exam findings or electrodiagnostic testing provided to show or suggest that the patient has ulnar nerve involvement at the elbow that warrant a nerve injection. The MTUS/ACOEM criteria for ulnar nerve involvement have not been met. The request for "Right ulnar epidural steroid injection at elbow" IS NOT medically necessary.

**Cervical epidural steroid injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** The 10/28/14 QME report states the patient has 9/10 neck pain but it does not radiate to the arm. MTUS Chronic Pain Treatment Guidelines, section on "Epidural steroid injections (ESIs)" page 46 states these are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." The MTUS Criteria for the use of Epidural steroid injections states: "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." There are no physical exam findings suggestive of radiculopathy, and no subjective radicular pain. There are no cervical MRI reports or electrodiagnostic studies provided. The MTUS guidelines for epidural injections has not been met. The request for cervical epidural steroid injection IS NOT medically necessary.