

Case Number:	CM15-0010706		
Date Assigned:	01/28/2015	Date of Injury:	09/06/2007
Decision Date:	03/26/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/20/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 33 year old female, who sustained an industrial injury on September 6, 2007. She has reported progressively worsening neck pain. The diagnoses have included cervicalgia, cervical facet arthropathy, cervical myofascial pain, cervical radiculitis, and lumbago. Treatment to date has included epidural steroid injection, urine drug screening, TTI, medial branch block with rhizotomy at right cervical 4-cervical 5, cervical 5-cervical 6, and cervical 6-cervical 7 in 2013, physical therapy, chiropractic therapy, acupuncture, and oral and topical pain, anti-epilepsy, antidepressants, and non-steroidal anti-inflammatory medications. On April 16, 2014, the injured worker underwent a left medial branch block at cervical 4-cervical 5, cervical 5-cervical 6, and cervical 6-cervical 7. On September 29, 2014, an MRI of the cervical spine revealed degenerative disc disease, most pronounced at cervical 5-cervical 6 and cervical 6-cervical 7. On December 23, 2014, the injured worker complained of neck and bilateral shoulder pain. There were spasms, stabbing, pins and needles, and burning pain with radiation down the neck to both arms. The cervical exam revealed decreased range of motion, Positive Spurling test, and negative bilateral Adson, bilateral Median stretch, and bilateral ulnar stretch tests. There was mild right upper extremity weakness, decreased sensation in the right cervical 6 and thoracic 1 dermatomes, and decreased right biceps and brachioradialis reflexes. The bilateral shoulder range of motion was normal. There was right shoulder pain with range of motion. On January 20, 2015, the injured worker submitted an application for IMR for review of a request for three (3) trigger point injections to each trapezii, Norco 5/325 1 tablet every 6 hours as needed for pain #120, a repeat EMG (electromyography), and a right medial branch block at

cervical 4-cervical 5, cervical 5-cervical 6, and cervical 6-cervical 7. The trigger point injections were non-certified based on lack of documentation of functional improvement from the previous trigger point injections. The Norco was modified based on the injured worker is not an appropriate candidate for long-term use of opiates and weaning of the Norco has been recommended in multiple previous reviews. Therefore, the Norco was modified to allow for weaning over 2-3 months. The EMG (electromyography) was non-certified based on the lack of evidence of neurological deficits on the physical exam, and the pending results of a recent MRI. The medial branch block was non-certified based on the injured worker had undergone a prior medial branch block followed by rhizotomy procedures. Only one medial branch block prior to proceeding with rhizotomy is recommended by the guidelines. The California Medical Treatment Utilization Schedule (MTUS), Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines (ODG) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Three (3) trigger point injections to each trapezii: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: With regard to trigger point injections, the MTUS CPMTG states: Recommended only for myofascial pain syndrome as indicated below, with limited lasting value." "Criteria for the use of Trigger point injections: Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. (Colorado, 2002) (BlueCross BlueShield, 2004)"The guidelines require assessment of benefit prior to repeat injections being performed. As the request is for a series of injections, the request is not medically necessary.

Retrospective request for Norco 5/325 mg #120 with a dos of 11/12/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone, When to Continue Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78, 91.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p78 regarding ongoing management of opioids "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. These domains have been summarized as the "4 A's" (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors).The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." The documentation submitted for review indicates that UDS has been inconsistent. Medical necessity cannot be affirmed. It should be noted that the UR physician has certified a modification of the request for #60 for weaning.

Repeat EMG of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177.

Decision rationale: ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. In this case, since the previous EMG demonstrated cervical radiculopathy on the right, and a new MRI has been done, and there is no operative planning noted, the request is not medically necessary.

Right medial branch block C4-C5, C5-C6, C6-C7 for facet arthropathy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174, 181.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Facet Joint Diagnostic Blocks

Decision rationale: The MTUS is silent on medial branch blocks. Per the ODG guidelines, facet joint medial branch blocks are not recommended except as a diagnostic tool, citing minimal

evidence for treatment. The ODG indicates that criteria for facet joint diagnostic blocks (injections) are as follows: 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a "sedative" during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)] As this request is for 3 levels, and the IW has been diagnosed with cervical radiculopathy, the request is not medically necessary.