

Case Number:	CM15-0127226		
Date Assigned:	07/13/2015	Date of Injury:	10/01/2010
Decision Date:	08/31/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	07/01/2015

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 (IW) is a 67 year old female who sustained an industrial injury on 10/01/2010. The mechanism of injury and initial report of injury are not found in the records reviewed. The injured worker was diagnosed as having status post C4-C7 fusion; right-sided C5 radiculopathy, ulnar neuropathy, cervicgia, facet joint pain, spasm of muscle, cervical spondylosis without myelopathy, and C7-T1 anterolisthesis. Treatment to date has included cervical fusion C4-C7, and nerve conduction studies of the bilateral upper extremities. Currently, the injured worker complains of neck pain with radiation into the right arms. On exam there is limited cervical range of motion, proprioception is normal, the sensation in the right lateral arm is diminished in the C5 distribution. Surgical scar on right elbow has healed. Medications include Tylenol #3, Amlodipine, and Cymbalta. There is a positive Tinel's at the right elbow. There is diminished finger strength in abduction on the right side. In a nerve conduction study of the upper extremity motor nerves and or nerve branches, the diagnoses were: other specific arthropathy involving other specified sites, spasm of muscle, cervicgia, lumbago, brachial neuritis or radiculitis not otherwise specified, thoracic or lumbosacral neuritis or radiculitis, unspecified, sprain of neck, thoracic sprain. A request for authorization is made for the following: 1 Facet block C7/T1, T1/T2; 2. Physical therapy 8 sessions; 3. Paracervical TPI (Trigger point injections (Retrospective 5/21/15)).

IMR ISSUES, DECISIONS AND RATIONALES

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

Facet block C7/T1, T1/T2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 300-301.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, under Facet joint diagnostic blocks.

Decision rationale: The patient was injured on 10/01/10 and presents with neck pain with radiation into the right arms. The request is for FACET BLOCK C7/T1, T1/T2. There is no RFA provided and the patient's current work status is not provided. Review of the reports provided does not indicate if the patient has had a prior facet block at C7/T1 and T1/T2. ODG-TWC, Neck and Upper Back Chapter, under Facet joint diagnostic blocks states: "Recommended prior to facet neurotomy (a procedure that is considered under study). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block. Criteria for the use of diagnostic blocks for facet nerve pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine. 2. Limited to patients with cervical 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 joint levels are injected in one session. 8. The use of IV sedation 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. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level." For facet joint pain signs and symptoms, the ODG guidelines state that physical examination findings are generally described as: 1. axial pain, either with no radiation or severely past the shoulders. 2. tenderness to palpation in the paravertebral areas, over the facet region; 3. Decreased range of motion, particularly with extension and rotation. 4. Absence of radicular and/or neurologic findings." The patient's cervical spine has palpable muscle spasm across the neck (right side greater than left with trigger points identified), increased pain to cervical extension and rotation, a positive right sided facet load, tenderness across the paracervical region on the right side over the facet joint, a positive Spurling's maneuver on the right side, and decreased sensation to the right C5 distribution. She is diagnosed with status post C4 through C7 fusion, right-sided C5 radiculopathy, ulnar neuropathy, cervicalgia, facet joint pain, spasm of muscle, cervical spondylosis without myelopathy, and C7-T1 anterolisthesis. Treatment to date has included cervical fusion C4-C7, and nerve conduction studies of the bilateral upper extremities. It does not appear as though the

patient had any previous facet block to the cervical spine at C7/T1 and T1/T2. In this case, the patient has cervical spine radiculopathy for which diagnostic facet blocks are not indicated per ODG Guidelines. Therefore, the requested facet block IS NOT medically necessary.

Physical therapy 8 sessions: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: The patient was injured on 10/01/10 and presents with neck pain with radiation into the right arms. The request is for PHYSICAL THERAPY 8 SESSIONS. The utilization review rationale is that the patient should be well versed at a home exercise program given the chronicity of the claim. There is no RFA provided and the patient's current work status is not provided. Review of the reports provided does not indicate if the patient has had any recent physical therapy. MTUS Guidelines, under Physical Medicine, pages 98 and 99 have the following: Physical medicine: Recommended as an indicated below. Allow for fading of treatments frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. MTUS Guidelines pages 98 and 99 state that for myalgia, myositis, 9 to 10 visits are recommended over 8 weeks, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits are recommended. The patient's cervical spine has palpable muscle spasm across the neck (right side greater than left with trigger points identified), increased pain to cervical extension and rotation, a positive right sided facet load, tenderness across the paracervical region on the right side over the facet joint, a positive Spurling's maneuver on the right side, and decreased sensation to the right C5 distribution. She is diagnosed with status post C4 through C7 fusion, right-sided C5 radiculopathy, ulnar neuropathy, cervicgia, facet joint pain, spasm of muscle, cervical spondylosis without myelopathy, and C7-T1 anterolisthesis. Treatment to date has included cervical fusion C4-C7, and nerve conduction studies of the bilateral upper extremities. There is no indication of any recent surgery the patient may have had. Given that the patient has not had any recent therapy, a course of therapy may be reasonable to help with her neck pain. The requested 8 sessions of physical therapy IS medically necessary.

Paracervical TPI (Trigger point injections (Retrospective 5/21/15): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, under Trigger Points Injection.

Decision rationale: The patient was injured on 10/01/10 and presents with neck pain with radiation into the right arms. The retrospective request is for a PARACERVICAL TPI (levels not indicated). There is no RFA provided and the patient's current work status is not provided. The 05/21/15 report states that the patient was given a repeat paracervical TPI today to help

treat her pain. The date and the results of this prior trigger point injection are not provided. The MTUS Guidelines, under Trigger point injections, page 122 states that 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. ODG Guidelines, Neck and Upper Back Chapter, under Trigger Points Injection, states the following: Not recommended in the absence of myofascial pain syndrome. See the pain chapter for criteria for the use of trigger point injections. The effectiveness of trigger point injection is uncertain, in part due to the difficulty of demonstrating advantages of active medication over injection of saline. Needling alone may be responsible for some of the therapeutic response. The only indication with some positive data is myofascial pain; maybe appropriate when myofascial trigger points are present on examination. Trigger point injections are not recommended when there are radicular signs, but they may be used for cervicgia. The patient's cervical spine has palpable muscle spasm across the neck (right side greater than left with trigger points identified), increased pain to cervical extension and rotation, a positive right sided facet load, tenderness across the paracervical region on the right side over the facet joint, a positive Spurling's maneuver on the right side, and decreased sensation to the right C5 distribution. She is diagnosed with status post C4 through C7 fusion, right-sided C5 radiculopathy, ulnar neuropathy, cervicgia, facet joint pain, spasm of muscle, cervical spondylosis without myelopathy, and C7-T1 anterolisthesis. Treatment to date has included cervical fusion C4-C7, and nerve conduction studies of the bilateral upper extremities. In this case, the levels for the requested trigger point injection are not indicated. It appears that the patient had a prior TPI but there is no documentation of its effect or benefit in terms of pain reduction, duration of relief and functional improvement. MTUS Guidelines state that repeat injections are not recommended unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement. Furthermore, the patient presents with radiculopathy for which TPI's are not supported by MTUS guidelines. The request does not meet guideline criteria. The requested trigger point injection to the cervical spine IS NOT medically necessary.