

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0166622 | | |
| Date Assigned: | 09/23/2015 | Date of Injury: | 11/01/2007 |
| Decision Date: | 11/06/2015 | UR Denial Date: | 08/24/2015 |
| Priority: | Standard | Application Received: | 08/25/2015 |

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 is a 58 year old female, who sustained an industrial injury on 11-01-2007. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for diabetes, degenerative disc disease of the cervical spine, lesion of the ulnar nerve, lateral epicondylitis, tenosynovitis radial styloid, and headaches. Medical records (03-30-2015) indicate ongoing and worsening of right shoulder pain since her last injection (10-2014) wore off. Pain levels were 0 out of 10 on a visual analog scale (VAS). There was also worsening of pain in the right elbow with increased numbness and tingling in the right upper extremity, and worsening of cervical pain and cervicogenic headaches. Records also indicate worsening ability to function and decreased activities without medications. Per the treating physician's progress report (PR), the IW was noted to be permanent and stationary, but work status was not mentioned. The physical exam, dated 08-04-2015, revealed tenderness at the anterolateral acromion, painful drop-arm test, painful Hawkin's, Neer's signs and O'Brien's test, tenderness along the right cubital tunnel, painful Tinel's sign, and a positive carpal tunnel provocative testing for pain but negative for numbness. Relevant treatments have included physical therapy (PT) resulting in worsening of pain and symptoms, a rhizotomy which helped trapezius pain, trigger point injections, Botox injections, work restrictions, and pain medications. The treating physician indicates that MRI of the cervical spine (2015 when compared to results from 2010) showing some new anterolisthesis at C4-5 without previous disc protrusion, and slightly increased bilateral neuroforaminal stenosis. There had also been electrodiagnostic studies of the left upper extremity which showed normal findings. The request for authorization (08-19-2015) shows that

the following procedures were requested: right cervical epidural steroid injection at C5-C6, left cervical epidural steroid injection at C5-C6, and a cervical epidurogram. The original utilization review (08-24-2015) modified the requests for right cervical epidural steroid injection at C5-C6 to the approval of one intralaminar entry for the right cervical epidural steroid injection at C5- C6; and modified the request for a left cervical epidural steroid injection at C5-C6 to the approval of one intralaminar entry for the left cervical epidural steroid injection at C5-C6. The utilization review also non-certified the cervical epidurogram based on the lack of medical necessity for epidural steroid injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Cervical Epidural Steroid Injection C5-C6: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The patient presents with neck pain, cervicogenic headaches and bilateral upper extremity pain. The request is for Right Cervical Epidural Injection C5-C6. Physical examination to the cervical spine on 04/20/15 revealed tenderness to palpation to the paracervical muscles with spasm. Patient's treatments have included image studies, Botox injections, radiofrequency ablation, and medication. Per 08/19/15 Request for Authorization form, patient's diagnosis include long term use meds nec, lesion ulnar nerve, epicondylitis lateral, tenosynovitis radial styloid, degeneration cervical disc, headache, pain psychogenic nec. Patient's medications, per 08/11/15 progress report include Pristiq, Hydrocodone/APAP, Gabapentin, Pennsaid, Glipizide, Metformin, Clonazepam, Trazadone, and Insulin. Patient is permanent and stationary. MTUS Chronic Pain Medical Treatment Guidelines 2009, page 46, Epidural Steroid Injections (ESIs) section states: "Criteria for the use of Epidural steroid injections: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3. Injections should be performed using fluoroscopy (live x-ray) for guidance. 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year." In appeal report dated progress report dated 06/23/15, treater states that the patient was seen by a spine specialist who recommended cervical epidural injection and prefers to reserve surgery as a last option. The patient continues with neck pain, pain in the bilateral upper extremities with numbness and tingling, and pain radiating along the medial aspect of bilateral scapulas. MRI findings of 05/07/15 showed worsening retrolisthesis, disc protrusion at C5-C6, creating mild to moderate central spinal canal stenosis as well as moderate to severe degenerative disc narrowing at C5-C6. Review of the medical records provided did not indicate a

prior injection. Given the patient's pain and corroborated image findings, the request appears to be reasonable. Therefore, the request is medically necessary.

Left Cervical Epidural Steroid Injection C5-C6: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The patient presents with neck pain, cervicogenic headaches and bilateral upper extremity pain. The request is for Left Cervical Epidural Injection C5-C6. Physical examination to the cervical spine on 04/20/15 revealed tenderness to palpation to the paracervical muscles with spasm. Patient's treatments have included image studies, Botox injections, radiofrequency ablation, and medication. Per 08/19/15 Request for Authorization form, patient's diagnosis include long term use meds nec, lesion ulnar nerve, epicondylitis lateral, tenosynovitis radial styloid, degeneration cervical disc, headache, pain psychogenic nec. Patient's medications, per 08/11/15 progress report include Pristiq, Hydrocodone/APAP, Gabapentin, Pennsaid, Glipizide, Metformin, Clonazepam, Trazadone, and Insulin. Patient is permanent and stationary. MTUS Chronic Pain Medical Treatment Guidelines 2009, page 46, Epidural Steroid Injections (ESIs) section states: "Criteria for the use of Epidural steroid injections: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3. Injections should be performed using fluoroscopy (live x-ray) for guidance. 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year." In appeal report dated progress report dated 06/23/15, treater states that the patient was seen by a spine specialist who recommended cervical epidural injection and prefers to reserve surgery as a last option. The patient continues with neck pain, pain in the bilateral upper extremities with numbness and tingling, and pain radiating along the medial aspect of bilateral scapulas. MRI findings of 05/07/15 showed worsening retrolisthesis, disc protrusion at C5-C6, creating mild to moderate central spinal canal stenosis as well as moderate to severe degenerative disc narrowing at C5-C6. Review of the medical records provided did not indicate a prior injection. Given the patient's pain and corroborated image findings, the request appears to be reasonable. Therefore, the request is medically necessary.

Cervical Epidurogram: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic)

chapter under Epidural Steroid Injections (ESIs) and Other Medical Treatment Guidelines
<http://www.ajnr.org/content/20/4/697.full>.

Decision rationale: The patient presents with neck pain, cervicogenic headaches and bilateral upper extremity pain. The request is for Cervical Epidurogram. Physical examination to the cervical spine on 04/20/15 revealed tenderness to palpation to the paracervical muscles with spasm. Patient's treatments have included image studies, Botox injections, radiofrequency ablation, and medication. Per 08/19/15 Request for Authorization form, patient's diagnosis include long term use meds nec, lesion ulnar nerve, epicondylitis lateral, tenosynovitis radial styloid, degeneration cervical disc, headache, pain psychogenic nec. Patient's medications, per 08/11/15 progress report include Pristiq, Hydrocodone/APAP, Gabapentin, Pennsaid, Glipizide, Metformin, Clonazepam, Trazadone, and Insulin. Patient is permanent and stationary. The MTUS, ACOEM and ODG guidelines do not discuss Epidurography specifically. The procedure, however, done along with an ESI, as per study published in the American Journal of Neuroradiology at <http://www.ajnr.org/content/20/4/697.full>. Regarding ESI, MTUS has the following to say under chronic pain section page 46 and 47, "Recommended as an option for treatment of radicular pain." MTUS has the following criteria regarding ESI's, under its chronic pain section: Page 46, 47 "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." ODG guidelines, chapter 'Pain (Chronic)' and topic 'Epidural Steroid Injections (ESIs)', state "In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year." In appeal report dated progress report dated 06/23/15, treater states that the patient was seen by a spine specialist who recommended cervical epidural injection and prefers to reserve surgery as a last option. The patient continues with neck pain, pain in the bilateral upper extremities with numbness and tingling, and pain radiating along the medial aspect of bilateral scapulas. MRI findings of 05/07/15 showed worsening retrolisthesis, disc protrusion at C5-C6, creating mild to moderate central spinal canal stenosis as well as moderate to severe degenerative disc narrowing at C5-C6. Given the patient's pain and corroborated image findings, cervical ESI would be indicated. However, injections of contrast to ensure proper placement of the injection is part of the ESI procedure. Additional billing for epidurogram is not discussed in any of the guidelines. The requested epidurography is not medically necessary.