

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: **12/12/2013**

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/1/2013
Date of Injury: 9/22/2008
IMR Application Received: 8/12/2013
MAXIMUS Case Number: CM13-0009453

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for **C7-T1 interlaminar epidural steroid injections (ESI) is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for **bilateral C3-C4-C5 medial branch block is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for **injection of myelogram/epidurogram is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the retrospective request for **trigger point injections - ten (10) is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the retrospective request for **fluoroscopic guidance is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/12/2013 disputing the Utilization Review Denial dated 8/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for **C7-T1 interlaminar epidural steroid injections (ESI)** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for **bilateral C3-C4-C5 medial branch block** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for **injection of myelogram/epidurogram** is not **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the retrospective request for **trigger point injections - ten (10)** is not **medically necessary and appropriate**.
- 5) MAXIMUS Federal Services, Inc. has determined the retrospective request for **fluoroscopic guidance** is not **medically necessary and appropriate**.

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

The enrollee is a 55-year-old male presenting with neck, shoulder, and back pain following a work-related injury on September 22, 2008. For the purpose of this dispute significant cervical and shoulder complaints intermittent neck radiating to the bilateral shoulders. The pain is associated with headaches and blurry vision. The pain is exacerbated by turning the head to the right or the left side. The physical exam was significant for non-dermatomal decreased sensation in both upper extremities, decreased range of motion in the cervical spine, tenderness over the bilateral before meals joints. MRI of cervical spine was significant for disc osteophyte complex of 2 mm at C3-4, 2-3 mm each at C4-5, 3-4 mm at C5-6 as well as a 3 mm disc bulge at C6-7 with mild C4-C5 through C6-C7 central canal narrowing, bilateral neuroforaminal narrowing which appears to be moderate to severe at C3-4, moderate at C4-5 and mild to moderate at both C5-6 and C6-7. The enrollee was diagnosed with multilevel cervical

degenerative disc disease/protrusion causing neuroforaminal stenosis, multilevel cervical spinal stenosis, cervical radiculopathy of the bilateral upper extremities, and multilevel cervical facet arthropathy. The provider performed C7-T1 interlaminar epidural steroid injections, bilateral C3-4-5 medial branch blocks, injection of myelogram/epidurogram, trigger point injections, and fluoroscopic guidance.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Treatment Utilization Schedule (MTUS)
- Medical Records from:
 - Claims Administrator
 - Employee/Employee Representative
 - Provider

1) Regarding the retrospective request for C7-T1 interlaminar epidural steroid injections (ESI):

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), and the Chronic Pain Medical Treatment Guidelines, which are part of the MTUS, and also the Official Disability Guidelines, Neck and Upper Back, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Epidural steroid injection, page 47, which is part of the MTUS.

Rationale for the Decision:

The cervical epidural steroid injection is not medically necessary per MTUS criteria for the use of epidural steroid injections. MTUS states that the purpose of epidural steroid injections is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery. MTUS also states that radiculopathy must be documented by physical examination and corroborated by imaging studies and or electrodiagnostic testing. The employee's presentation does not provide evidence for radiculopathy specifically on imaging which documented an MRI of the cervical spine significant for multilevel disc bulge without nerve root compression. Therefore, a cervical epidural steroid injection in this case is not medically necessary **The retrospective request for C7-T1 interlaminar epidural steroid injections (ESI) is not medically necessary and appropriate.**

2) Regarding the retrospective request for bilateral C3-C4-C5 medial branch block:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), and the Chronic Pain Medical Treatment Guidelines, which are part of the MTUS, and also the Official Disability Guidelines, Neck and Upper Back, which is not part of the MTUS..

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 12, pgs. 300-301, which are part of the MTUS.

Rationale for the Decision:

Bilateral C3-4-5 medial branch block is not medically necessary. ACOEM, chapter 12 page 301 states that invasive techniques including facet joint injections are of questionable merit. Additionally, the requested procedure becomes non-certifiable because this procedure was performed at the same time as the cervical epidural steroid injection. Each procedure treats a different disorder. In performing both, makes it difficult to qualify the employee's response to therapy. It is not medically necessary to combine this medial branch blocks with cervical epidurals steroid injections and trigger point injections. **The retrospective request for bilateral C3-C4-C5 medial branch block is not medically necessary and appropriate.**

3) Regarding the retrospective request for injection of myelogram/epidurogram:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), and the Chronic Pain Medical Treatment Guidelines, which are part of the MTUS, and also the Official Disability Guidelines, Neck and Upper Back, which is not part of the MTUS..

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Epidural steroid injection, page 47, which is part of the MTUS.

Rationale for the Decision:

Myelogram/epidurogram is not medically necessary. Epidurogram is often billed with cervical epidural steroid injection performed under fluoroscopy. Given that there is a lack of medical necessity for the cervical epidural steroid injection per California MTUS page 47, the myelogram/epidurogram is not medically necessary as well. **The retrospective request for injection of myelogram/epidurogram is not medically necessary and appropriate.**

4) Regarding the retrospective request for trigger point injections - ten (10):

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), and the Chronic Pain Medical Treatment Guidelines, which are part of the MTUS, and also the Official Disability Guidelines, Neck and Upper Back, which is not part of the MTUS..

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Criteria for Trigger Point injections, Page 122, which is part of the MTUS, and Tough, Elizabeth A. et al. Validity of Criteria Used to Diagnose Myofascial Trigger Point Pain Syndrome-Evidence From a Review of the Literature Clinical Journal of Pain. 2007; 23(3): 278-286, which is not part of the MTUS.

Rationale for the Decision:

Trigger point injections are not medically necessary per MTUS guidelines which states that these injections are recommended for low back or neck pain with myofascial pain syndrome, when there is documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. The employee's medical records do not document the presence or palpation of trigger points along the area of the neck where the injection is to be performed.

There is also a paucity of medical literature, supporting the safety and long term efficacy of the requested services in treating the employee's chronic medical condition. Tough et al. (Clinical Journal of Pain, 2007) performed a literature review to investigate the criteria adopted by experts to diagnose myofascial trigger point pain syndrome. The authors concluded that there is limited consensus on case definition in respect to myofascial trigger point pain syndrome. Further research is needed to test the reliability and validity of diagnostic criteria. Until reliable diagnostic criteria have been established, there is a need for greater transparency in research papers on how a case of myofascial trigger point pain syndrome is defined and claims for effective interventions in treating the condition should be viewed with caution. **The retrospective request for trigger point injections - ten (10) is not medically necessary and appropriate.**

5) Regarding the retrospective request for fluoroscopic guidance:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), and the Chronic Pain Medical Treatment Guidelines, which are part of the MTUS, and also the Official Disability Guidelines, Neck and Upper Back, which is not part of the MTUS..

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

Rationale for the Decision:

Flourosopic guidance is not medically necessary. Flourosopic guidance is often billed with a spinal injection. Given that there is a lack of medical necessity for the cervical epidural steroid injection per California MTUS page 47 and cervical medial branch blocks per ACOEM chapter 12 page 301, the flouroscopy is not medically necessary as well. **The retrospective request for fluoroscopic guidance is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/ldh

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.