

Case Number:	CM14-0156382		
Date Assigned:	09/25/2014	Date of Injury:	06/01/2011
Decision Date:	12/19/2014	UR Denial Date:	08/21/2014
Priority:	Standard	Application Received:	09/24/2014

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. The expert 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 45-year-old female presenting with a work-related injury on June 1, 2011. The patient was diagnosed with cervicalgia, cervical MPN: no spondylosis, cervical disc degeneration, bilateral cubital tunnel, and right shoulder bursal rotator cuff tear. EMG nerve conduction study on August 12, 2011 revealed left C6 radiculopathy and mild right ulnar neuropathy. MRI of the cervical spine on August 11 revealed disc herniation C5 - C6. EMG nerve conduction study on March 24, 2014 showed abnormal study, electrodiagnostic evidence of mild to moderate ulnar neuropathy at the right elbow, without evidence of acute or chronic denervation, electrical findings suggestive of developing mild median neuropathy at the right wrist. On January 13, 2014 the patient complained of chronic neck pain associated with numbness/tingling in the medial forearm and digits four - five on bilateral upper extremities, right worse than left. The patient reported physical therapy is most helpful for symptoms. The patient also reported acupuncture was helpful although effects would wear off. The physical exam was significant for range of motion of the neck is extension to 60 and flexion is 45; range of motion of the wrist extension to 80, flexion to 80, pronation to 80 and supination 80 without pain; cervical exam was positive for paracervical tenderness, positive Spurling's, elbow exam positive and all the text that flexion test bilaterally; positive Tinel's at the cubital tunnel to the fourth and fifth finger on the right; tenderness at the cubital tunnel on the right; partial select and ulnar nerve; positive tenderness at the extensor origin and the flexor/pronator origin; hand exam was positive for carpal tunnel Durkan's compression test; sensation subjectively decreased in the fourth and fifth finger and grip strength: right 22/22/18, left 22/19/22. The patient was diagnosed with carpal tunnel syndrome, ulnar nerve lesion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left cervical facet injection C5-6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Complaints, Treatment Consideration

Decision rationale: Left cervical facet injection at C5-6 is not medically necessary. The guidelines criteria for use of diagnostic facet blocks require: that the clinical presentation be consistent with facet pain; Treatment is also limited to patients with cervical pain that is non-radicular and had no more than 2 levels bilaterally; documentation of failed conservative therapy including home exercise physical therapy and NSAID is required at least 4-6 weeks prior to the diagnostic facet block; no more than 2 facet joint levels are injected at one session; recommended by them of no more than 0.5 cc of injectate was given to each joint; no pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4-6 hours afterward; opioid should not be given as a sedative during the procedure; the use of IV sedation (including other agents such as modafinil) may interfere with the result of the diagnostic block, and should only be given in cases of extreme anxiety; the patient should document pain relief with the management such as 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 level to support subjective reports of better pain control; diagnostic blocks should not be performed in patients in whom a surgical procedures anticipated; diagnostic facet block should not be performed patients who have had a previous fusion procedure at the plan injection level. The physical exam does not clearly indicate facet pain. The physical exam revealed a positive spurling's test which is indicative of radicular pain. Additionally, the patient reported radiating pain; therefore the requested procedure is not medically necessary.

Left cervical facet injection C6-7: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low Back-Lumbar & Thoracic

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 Shoulder Complaints, Treatment Consideration

Decision rationale: Left cervical facet injection at C6-7 is not medically necessary. The guidelines criteria for use of diagnostic facet blocks require: that the clinical presentation be consistent with facet pain; Treatment is also limited to patients with cervical pain that is non-radicular and had no more than 2 levels bilaterally; documentation of failed conservative therapy

including home exercise physical therapy and NSAID is required at least 4-6 weeks prior to the diagnostic facet block; no more than 2 facet joint levels are injected at one session; recommended by them of no more than 0.5 cc of injectate was given to each joint; no pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4-6 hours afterward; opioid should not be given as a sedative during the procedure; the use of IV sedation (including other agents such as modafinil) may interfere with the result of the diagnostic block, and should only be given in cases of extreme anxiety; the patient should document pain relief with the management such as 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 level to support subjective reports of better pain control; diagnostic blocks should not be performed in patients in whom a surgical procedure anticipated; diagnostic facet block should not be performed patients who have had a previous fusion procedure at the plan injection level. The physical exam does not demonstrate cervical facet pain. The physical exam revealed a positive spurling's test which is indicative of radicular pain. Additionally, the patient reported radiating pain; therefore the requested procedure is not medically necessary.