

Case Number:	CM14-0039928		
Date Assigned:	07/02/2014	Date of Injury:	03/28/2012
Decision Date:	09/22/2014	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	04/04/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in California. 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 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 55-year-old female who reported injury on 03/28/2012. The mechanism of injury was a fall. Diagnoses included cervical spondylosis and cervical radiculopathy. The past treatments included an epidural steroid injection at C7-T1 on 11/18/2013 with "some improvement" and 8/10 pain noted 4 weeks afterward, and cervical facet blocks "last year" which gave her an 80-90% reduction in pain that lasted 3-4 days. The MRI dated 06/29/2013, revealed severe left facet degenerative changes, severe left neural foraminal narrowing, and mild-to-moderate spinal stenosis at the C2-3 level. There was moderate left facet degenerative changes, mild to moderate disc space narrowing, severe left neural foraminal narrowing, and mild-to-moderate spinal stenosis at the C3-4 level. Per the pain management progress note, dated 03/19/2014, the injured worker complained of pain in her upper neck and the back of her head causing headaches. The physical exam indicated tenderness to the high left cervical spine, anterior flexion of the neck to 60 degrees, mildly limited by pain, extension to 60 degrees, mildly limited by pain, lateral rotation to 80 degrees bilateral, mildly limited by pain, and normal motor strengths. Medications included tramadol 50mg twice a day. The treatment plan noted the injured worker was awaiting approval for cervical fusion surgery, and recommended another block to help reduce the injured worker's pain while she waits for her surgery, citing the 80-90% improvement with the previous facet block. The request for Authorization form was submitted for review 03/19/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Cervical Facet Block C2-3, C3-4 under Fluoroscopy and Anesthesia: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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, Facet joint therapeutic steroid injections, Facet joint diagnostic blocks.

Decision rationale: The Expert Reviewer's decision rationale: The request for left cervical facet block C2-3, C3-4 under fluoroscopy and anesthesia is not medically necessary. The Official Disability Guidelines do not recommend therapeutic facet joint injections. However, if therapeutic injections are used, the guidelines indicate the clinical presentation should be consistent with facet joint pain signs and symptoms with no evidence of radicular pain, spinal stenosis, or fusion. There should be evidence of a formal plan of rehabilitation in addition to facet joint injection therapy. The injured worker had cervical facet blocks "last year" which gave her an 80-90% reduction in pain that lasted 3-4 days. The injured worker was noted to have neck pain and left facet joint degeneration at the C2-3 and C3-4 levels; however, mild-to-moderate spinal stenosis was noted at both levels. There is a lack of documentation indicating the injured worker has significant facet tenderness with positive facet loading at the requested levels and full range of motion was documented. The requesting physician did not indicate the injured worker has a negative neurologic assessment. There is no evidence of a formal plan of rehabilitation in addition to facet joint injection therapy. Additionally, there is no documentation indicating the injured worker has significant anxiety related to the procedure, which would demonstrate the need for anesthesia. Given that facet joint blocks are not recommended for pain management, especially with indication of spinal stenosis, the lack of evidence to support prior success, and the lack of physical examination findings, a therapeutic facet block is not supported at this time therefore, the request is not medically necessary.