

Case Number:	CM14-0093629		
Date Assigned:	07/25/2014	Date of Injury:	05/05/2011
Decision Date:	09/26/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	06/20/2014

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 and 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 injured worker is a 50-year-old male who reported an injury on 05/05/2011. While lifting a 300 pound patient, he strained his right shoulder. Diagnoses were C2-3 disc protrusion with right greater occipital neuralgia, status post 04/2013 right labral surgery, C5-6 degenerative disc disease with osteophyte annular tear and central canal stenosis contributing to myofascial trapezius pain. Past treatments were acupuncture, physical therapy, and bracing. MRI of the cervical spine on 11/12/2013 revealed C2-C5 levels appeared unremarkable except for possibly a very tiny central protrusion noted at C3-C4 measuring 1 mm suspicious for annular tear with no significant stenosis. At C5-C6 there was mild to moderate annular disc bulging/endplate spurring along the central, left paracentral and left lateral aspect of the disc with combined disc/osteophyte encroachment measuring 2 to 3 mm along the left paracentral aspect of the disc in conjunction with subtle signal increase along the disc periphery suspicious for a left paracentral annular tear. There was borderline narrowing of the central canal without significant central stenosis. Surgical history was right shoulder arthroscopy with rotator cuff reconstruction, and labral tear repair. Physical examination on 06/03/2014 revealed complaints of neck pain rated at an 8/10 to 9/10. The injured worker reported the pain radiated into the right shoulder and was rated a 6/10. The injured worker had undergone greater occipital injection for right sided headaches which, for a couple of days after the injection, had given him more severe headaches. The injured worker stated the pain was left sided pain which started at the base of the skull and radiated up behind his left ear, which caused him to clench his teeth on the right side. He stated that this was a new symptom for him. The injured worker reported he had pain lifting his own head. It was reported that he pain was aggravated with rotation and side bend of the head. Physical examination revealed cervical flexion elicited pain from behind the left ear to the base of the skull, and radiated to the left trapezius. Extension was to 20 degrees and elicited pain

that radiated from the left ear to the left trapezius, out to the left shoulder. Side bend to the right was to 15 degrees, and side bend to the left was to 5 degrees, which elicited left sided neck and ear pain that radiated to the left trapezius. Rotation was to the right for 50 degrees, and elicited left sided ear pain that radiated to the left trapezius. Rotation to the left elicited left posterior ear pain to the left trapezius. There was tenderness to palpation along the midline C3 through T1 in the bilateral paraspinals, as well as the upper trapezius bilaterally. Medications were Norco 5/325 mg 1 tablet 3 times a day. The treatment plan was to order physical therapy and facet injections. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical facet injection: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, neck chapter.

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 Blocks.

Decision rationale: The request for Cervical facet injection is certified. The Official Disability Guidelines state for facet joint diagnostic blocks is recommended prior to facet neurotomy (a procedure that is considered understudied). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Criteria for the use of diagnostic blocks are facet nerve pain or 1 set of diagnostic medial branch blocks is required with a response of 70% or greater pain relief. The pain response should be approximately 2 hours for lidocaine. Limited to patients with cervical pain that is nonradicular and at no more than 2 levels bilaterally. There should be documentation of failure of conservative treatment (including home exercise, physical therapy and NSAIDs) prior to the procedure for at least 4 to 6 weeks. No more than 2 joint levels are injected in 1 session. Recommended volume of no more than 0.5 cc of injectate is 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 to 6 hours afterward. Opioids should not be given as a sedative during the procedure. The use of IV sedation may be grounds to negate the results of the diagnostic block, and should only be given in cases of extreme anxiety. 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. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections, stellate ganglion blocks, sympathetic blocks, or trigger point injections, as this may lead to improper diagnosis or unnecessary treatment. According to the records submitted for review, the injured worker has been complaining of cervical pain since

04/2013. The injured worker reported that he is having a new symptom. The injured worker had obvious limitations of range of motion. Therefore, the request is medically necessary.