MAXIMUS Federal Services

Case Number:	CM15-0208263		
Date Assigned:	10/29/2015	Date of Injury:	11/17/2005
Decision Date:	12/23/2015	UR Denial Date:	10/01/2015
Priority:	Standard	Application Received:	10/22/2015

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: Massachusetts
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 48-year-old male with a date of industrial injury 11-17-2005. The medical records indicated the injured worker (IW) was treated for facet arthralgia; cervicogenic headache; chronic pain due to trauma; cervical root lesions, not elsewhere classified; myalgia and myositis, unspecified; whiplash trauma to neck; and other and unspecified disc disorder of the cervical region. In the 9-21-15 progress notes, the IW reported moderate to severe pain in the middle back, lower back, neck and shoulders. He rated his pain 8 out of 10 without medications, 6 out of 10 with them and 7 out of 10 as his average pain over the last month. On a 0 to 10 scale, he rated pain interference with daily activities in the last month as a '9'. Medications were Paxil and Amitiza. On examination (9-21-15 notes), there was tenderness over the C2-3 through C4-5 levels bilaterally, greater on the left; range of motion was limited. Sensory and motor exams were normal. Treatments included physical therapy, chiropractic treatment, acupuncture and spinal injections. He had a C7-T1 intralaminar epidural steroid injection on 5-13-15 which was not helpful. MRI of the cervical spine on 3-19-14 showed mild multilevel degenerative disc disease without significant spinal stenosis; there was mild bilateral foraminal stenosis at C4-5. The IW was working full time without restrictions. There was no record of previous facet injections. The most recent exam did not suggest radicular symptoms. A Request for Authorization was received for facet injections bilateral C2-3, C3-4 and C4-5 with anesthesia and IV sedation. The Utilization Review on 10-1-15 non-certified the request for facet injections bilateral C2-3, C3-4 and C4-5 with anesthesia and IV sedation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral facet injections at C2-3, C3-4, and C4-5 with anesthesia and IV sedation: 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).

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 (Acute & Chronic), Facet joint diagnostic blocks.

Decision rationale: The claimant sustained a work injury in November 2005 as the result of a high-speed motor vehicle accident with injuries to the neck and low back. In May 2015, he underwent an interlaminar cervical epidural injection including use of fentanyl and midazolam for sedation. When seen in September 2015 the injection had not helped. He reported feeling "fabulous" when leaving after the injection attributed to medications and local anesthetic. He was having neck, mid back, low back, and shoulder pain. He was having radiating symptoms into the right thigh. Pain was rated at 6/10 with medications. Physical examination findings included a body mass index of 28.5. There was decreased and painful range of motion throughout the spine. There was bilateral multilevel cervical tenderness. Authorization was requested for bilateral three level cervical facet blocks using moderate sedation. Diagnostic facet joint blocks are recommended with the anticipation that, if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Criteria include patients with cervical pain that is non-radicular after failure of conservative treatment such as physical therapy, non-steroidal anti-inflammatory medication, and a home exercise program. No more than two joint levels are to be injected in one session. Opioids medication such as Fentanyl should not be given as a sedative during the procedure and the use of intravenous sedation including agents such as Versed (midazolam) may be considered as negating the results of a diagnostic block. In this case, a three level procedure is being requested which is in excess of that recommended. Moderate sedation is also being requested and, based on the claimant's reported response immediately after the epidural steroid injection done in May 2015; there would be a high likelihood that any positive response to the procedure would be negated through the use of moderate sedation. The requested facet injections are not medically necessary.