

Case Number:	CM15-0056097		
Date Assigned:	04/01/2015	Date of Injury:	09/16/1998
Decision Date:	08/25/2015	UR Denial Date:	03/16/2015
Priority:	Standard	Application Received:	03/24/2015

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:

The injured worker is a 54 year old female who sustained an industrial injury on 09/16/1998. Mechanism of injury was from repetitive use of a baton, while in training and injuring her neck, upper back, and shoulder. Diagnoses include cervical spondylosis, shoulder joint pain, and lumbosacral spondylosis. Treatment to date has included diagnostic studies, medications, status post C5-7 fusion, injections, and physical therapy. Her medications include Percocet, Ultram ER, Gabapentin, Cyclobenzaprine, Fenoprofen and Theramine. An unofficial report of a Magnetic Resonance Imaging of the lumbar spine revealed a large extruded L5-S1 disc herniation. There is impingement over the left traversing L5 and S1 nerve root exiting left L5 nerve root. There is facet hypertrophy bilateral at L4-5 and L5-S1. A physician progress note dated 02/06/2015 documents the injured worker is complaining of decreased pain in her right shoulder since she received the injections. She complains of pain in the right side of her neck when she rotates her head to the right side and now she is dropping objects and intermittently has complete loss of strength in her hand to the extent that she is not able to type on her cell phone. She rates her neck and shoulder pain at 5 out of 10. Right sided facet joint provocation had significant decreased range of motion and was exquisitely painful. There is severe muscle spasm in the right cervical spine. On unofficial report of examination under fluoroscopy showed a solid fusion at C5-C6, C6-C7 with facet arthropathy C4-5 and C7-T1 bilaterally. The left-sided radicular pain has completely subsided and mostly gone away since the lumbar epidural injections, left L4-5 and L5-S1 for a large L5-S1 disc extrusion herniation. Her pain is now localized mostly in the back but is it bearable. The shooting pain with tingling, and numbness down the leg is gone. She has diffuse pain in the left low back and rates it 4-5 out of 10, but it does respond to medication.

Left leg straight leg raise is positive. Lumbar spine range of motion is restricted. The treatment plan includes refilling of her medications, and a urine drug screen. Treatment requested is for Outpatient diagnostic facet injection right side C4-5 and C7-T1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient diagnostic facet injection right side C4-5 and C7-T1: 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 and Upper Back Chapter, Diagnostic Blocks for facet nerve pain.

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 has a remote history of a work injury occurring in 1998 and treatments have included a multilevel cervical fusion from C5 to C7. When seen, she was having neck pain when rotating her neck to the right. Physical examination findings included right cervical spine muscle spasms and pain and decreased range of motion with right-sided facet joint testing. There was decreased right upper extremity sensation with normal strength. Imaging under fluoroscopy had shown facet arthropathy above and below the level of the claimant's prior fusion. Authorization for diagnostic facet joint injections was requested. 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. In this case, the claimant has failed other conservative treatments. There are no radicular symptoms. She has right sided pain with restricted range of motion. The number of facet blocks is within guideline recommendations and would be performed above and below the level of the prior fusion. The request is both appropriate and medically necessary.