

Case Number:	CM15-0099045		
Date Assigned:	06/01/2015	Date of Injury:	09/24/2001
Decision Date:	07/07/2015	UR Denial Date:	04/30/2015
Priority:	Standard	Application Received:	05/22/2015

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: Florida

Certification(s)/Specialty: Neurology, 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 61-year-old female, who sustained an industrial injury on September 24, 2001. Several documents included in the submitted medical records are difficult to decipher. The injured worker's initial complaints and diagnoses are not included in the provided documentation. The injured worker was diagnosed as having cervical postlaminectomy syndrome, cervical spondylosis, cervical degenerative disc disease, occipital neuralgia, and headache - probable cervicogenic. On March 18, 2010, an MRI of the cervical spine revealed a previous anterior fusion at the cervical 5-6 level, mild degenerative changes w. disc disease of the cervical spine without significant central stenosis, and a small central protrusion at the cervical 6-7 level that did not cause significant stenosis. On August 30, 2012, an MRI of the cervical spine revealed a prior anterior cervical fusion at cervical 5-cervical 6 with interval development of a central and right paramedian disc extrusion at the cervical 4-cervical 5 level. There was mild narrowing of the central canal without any direct neural compression. In September 2009, an electromyography study was negative, and in February 2012 the injured worker reported that a recent electromyography study was negative. On March 30, 2015, x-rays of the cervical spine revealed anterior cervical fusion C 5-cervical 6 with artificial disc placement at cervical 4-cervical 5 and cervical 6-7, stable fusion and artificial components, no acute fractures, patent foramina, and no intersegmental instability. The physical exam revealed tenderness to palpation of the lateral epicondyle of the left elbow, pain of the left elbow with restricted finger extension, decreased sensation to the light touch in the left medial hand and all of the finger tips. Treatment to date has included acupuncture, physical therapy, occipital nerve

blocks, trigger point injections, psychotherapy, and medications including pain, antidepressant, muscle relaxant, anti-anxiety, proton pump inhibitor, anti-emetic, migraine, and non-steroidal anti-inflammatory. On April 3, 2015, the injured worker complains of occasional sharp, stabbing pain in the right ear canal, which she feels comes from the right neck. Associated symptoms include ringing in the right ear, right side of throat/anterior neck spasms, and voice hoarseness. She complains of ongoing, moderate to severe right shoulder pain that usually worsens as the day progresses; numbness and tingling of the left fourth and fifth fingers and occasional sharp pain of the left second finger; and increased headaches since stopping acupuncture. Her pain medication provides 60-70% relief of the right shoulder pain 3-4 hours. She experiences daily headaches with 6-8days/month of more severe headaches that require migraine medication, which decreases her headache pain by at least 50%. Her pain level is 6 on a visual analogue scale. The physical exam revealed restricted and painful neck range of motion, a well healing neck scar, and increased hypertonicity throughout the cervical paraspinal, trapezius, and rhomboid muscles. The injured worker's work status is temporarily totally disabled. The treatment plan includes medical branch block for the bilateral cervical 2-cervical 3 and cervical 3-cervical 4 levels.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial Branch Block for the Bilateral C2-C3 and C3-C4 Levels under Fluoroscopy and Conscious Sedation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation official disability guidelines - neck, facet block.

Decision rationale: The medical records provided for review report back pain but do not document physical examination findings consistent with facet mediated pain. Further ODG guidelines do not support more than 2 levels of facet injection in the case of an injured worker having demonstrated physical exam findings of facet mediated pain. The medical records provided for review do not demonstrate findings in support of the bilateral C2-C3 and C3-C4 Levels under Fluoroscopy and Conscious Sedation congruent with ODG guidelines. The request is not medically necessary.