

<b>Case Number:</b>	CM13-0050750		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	02/08/2012
<b>Decision Date:</b>	05/21/2014	<b>UR Denial Date:</b>	10/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/13/2013

### 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 Texas and Oklahoma. 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 39-year-old male who reported an injury on 02/08/2012. The mechanism of injury was the injured worker was up on a ladder and wearing a harness that connected him to the ladder. The injured worker was reaching out to clean a junction box when he was electrocuted and the next thing he new he was falling. It was indicated the injured worker did not remember being electrocuted and the next thing he remembered was that his friends were helping him down from a ladder where he was hanging by his harness. A neurodiagnostic impression of 07/15/2013 revealed the injured worker had a normal median, ulnar, and radial nerve conduction study and normal electromyographic studies in the upper extremities with absent findings of mononeuropathy, polyneuropathy, cubital tunnel syndrome, carpal tunnel syndrome, peripheral neuropathy, or cervical radiculopathy. The injured worker had an MRI of the cervical spine on 07/02/2013, which revealed no facet arthropathy at the levels of C2 through C6. There was mild disc desiccation with no disc hernations, spinal canal stenosis or foraminal narrowing. The documentation of 10/07/2013 revealed the injured worker had pain in the neck, lower back, and a headache. The pain level had increased since the last visit. There were no physical examination findings noted for the cervical spine. The diagnosis was cervical facet syndrome, cervical pain, myalgia, and myositis, NOS, and post concussion syndrome. The injured worker indicated the pain occurred constantly and the injured worker had complaints of dizziness, anxiety, confusion, and an abnormal gait, memory loss, muscle spasms, numbness, tingling and weakness. Subsequent documentation of 03/17/2014 revealed the injured worker had decreased range of motion and tenderness in the paracervical muscles and trapezius. The motor examination revealed the deltoids of 3/5 on the left and biceps flexion of the forearm muscle strength of grade 3 against gravity. The request again was made for a cervical facet nerve block at C3 through C6.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **A CERVICAL FACET MEDIAL BRANCH BLOCK AT BILATERAL C2-C5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Criteria for the use of diagnostic blocks for facet nerve pain.

**Decision rationale:** ACOEM guidelines indicate that diagnostic facet joints have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injections may help patients presenting in the transitional phase between acute and chronic pain. As such, application of secondary guidelines were sought. Per Official Disability Guidelines criteria for the use of diagnostic blocks for facet nerve pain include "clinical presentation should be consistent with facet joint pain, signs and symptoms which include unilateral pain that does not radiate past the shoulder, objective findings of axial neck pain (either with no radiation or rarely past the shoulders), tenderness to palpation in the paravertebral areas (over the facet region); a decreased range of motion (particularly with extension and rotation) and the absence of radicular and/or neurologic findings. If radiation to the shoulder is noted pathology in this region should be excluded. There should be one set of diagnostic medial branch blocks is required with a response of  $\geq 70\%$ . The injured worker had decreased range of motion and neck pain. There was documentation indicating the injured worker had radicular findings of motor strength of 3/5 in the deltoid on the left and biceps flexion at forearm muscle strength of grade 3. Given the above, and the objective findings of radiculopathy, the request for a cervical facet medial branch block at bilateral C2 through C5 is not medically necessary.