

Case Number:	CM13-0055092		
Date Assigned:	12/30/2013	Date of Injury:	01/17/2007
Decision Date:	03/17/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	11/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 physician 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 patient is a injured worker with a date of injury of January 17, 2007. The utilization review determination dated October 17, 2013 recommends non-certification of medial branch block on the left side at C2, C3, C4, and C5. The utilization review determination indicates that the patient has had facet blocks in the past without relief. Additionally, the request is for 3 joint levels whereas a maximum of 2 are supported by guidelines. A progress report dated September 3, 2013 identifies subjective complaints of neck pain which radiates to the shoulders, arms, and headaches. The pain is rated as 8/10. Physical examination reveals crepitus in the cervical spine and difficulty with extension. The medical note indicates that there is intermittent radicular pain to his left more than right hand, and facet tenderness bilaterally. Current diagnoses include chronic neck pain and arm pain, cervical spondylosis with severe transformation and cervicogenic headaches. The treatment plan recommends continuing medication as well as request left C2, C3, C4, C5 medial branch block due to severe neck pain and cervicogenic headaches. A progress report dated July 5, 2012 indicates that the patient is a candidate for diagnostic cervical facet blocks at C5-6 and C6-7. An EMG nerve conduction study dated January 31, 2013 includes a diagnosis of chronic bilateral C6 poly radiculopathy. A progress report dated January 31, 2013 indicates that the patient has previously undergone physical therapy. A progress report dated April 4, 2013 indicates that the patient has radiculopathy bilaterally at C5-7 with decreased sensation. An operative report dated June 20, 2013 indicates that the patient underwent C-5-6 and C6-7 facet blocks with fluoroscopy. A progress report dated July 11, 2013 indicates that the facet injections may have helped, for one day. A progress report dated June 27, 2013 indicates that the patient had 60% pain reduction following cervical facet block.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial Branch Block (MBB) left at C2, C3, C4, and C5: 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), Treatment in Workers Compensation, 2013 web based edition.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter Facet Joint Diagnostic Blocks, Facet Joint Pain Signs and Symptoms, and Facet Joint Therapeutic Steroid Injections.

Decision rationale: The Physician Reviewer's decision rationale: This is an incomplete prescription. The type, duration and frequency of the weight loss program were not provided. The patient's weight from 6/24/13 was 226 lbs. her height is not reported, so BMI cannot be calculated. It is speculated that the BMI was under 35, as this would be the requirement for the total knee replacement that the patient underwent on 5/20/13 and 11/6/13. . ODG guidelines appear to suggest that even without a formal weight loss program, "Obese patients may have clinically significant weight loss after total joint arthroplasty, since their osteoarthritis had limited their mobility and ability to exercise." However, without the duration or frequency, the request cannot be compared to duration and frequency recommended under the nationally recognized professional standards . The request for an outpatient weight loss program is not medically necessary or appropriate.