

Case Number:	CM13-0056875		
Date Assigned:	12/30/2013	Date of Injury:	08/18/2006
Decision Date:	04/01/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	11/24/2013

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. He/she has been in active clinical practice for more than five years and is currently working least at 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 53-year-old female who reported an injury on 08/18/2006. The mechanism of injury was noted to be a fall. The patient was noted to have multiple cervical epidural steroid injections. The patient's pain on the Visual Analog Scale was 6/10 to 8/10. The patient had reported constant neck pain and headaches shooting down the upper extremity. The patient indicated they were more on the right than the left with associated tingling, numbness, and paresthasias. The left sided Spurling's maneuver was positive. The hyperextension maneuver of the left spine was positive. There was loss of normal lordotic curve of the cervical spine. The patient had paravertebral muscle spasm and localized tenderness in the lower cervical and uncovertebral joints. There was non-dermatomal diminished sensation to light touch in the upper extremity. The patient's diagnosis was noted to be central/right disc protrusion at C6-7 level, central canal stenosis from C4 through C6, right paracentral/lateral disc protrusion at C5-6, disc bulge at C3-4, status post left shoulder rotator cuff repair, full thickness tears of the distal supraspinatus tendon, left cervical radiculitis, chronic myofascial pain syndrome, and chronic C5-6 dorsal rami involvement. The plan was noted to be as the patient had a severe escalation of neck pain with headache, the patient would benefit from a bilateral C5-6 and medial branch block. Additionally, the patient would continue medications including naproxen 550 mg, Neurontin 600 mg, Zanaflex, and Prilosec as well as Polar Frost.

IMR ISSUES, DECISIONS AND RATIONALES

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

One time bilateral C5-C6 medial branch blocks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 174.

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 & Upper Back Chapter, Facet injection, diagnostic

Decision rationale: ACOEM Guidelines indicate that there is limited evidence that radiofrequency neurotomy may be effective in relieving or reducing cervical facet joint pain among patients who had a positive response to facet injections. As there was not specific criterion for performance of a facet joint diagnostic block, secondary guidelines were sought. Official Disability Guidelines indicate that the patient should have a clinical presentation that is consistent with facet joint pain signs and symptoms which include unilateral pain that does not radiate past the shoulder, axial neck pain, tenderness to palpation in the paravertebral area, decrease range of motion in the absence of radicular and/or neurologic findings. It should be limited to patients with cervical pain that is non-radicular and at no more than 2 levels bilaterally and there should be documentation of a failure of conservative treatment prior to the procedure for at least 4 to 6 weeks. The clinical documentation submitted for review failed to indicate the patient had unilateral pain that did not radiate past the shoulder as the patient indicated that it shot down her upper extremities, right more than left with tingling, numbness, and paresthesia. The patient had tenderness to palpation of the paravertebral area and had a Spurling's maneuver that was positive which is indicative of radicular pain. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for 1 time bilateral C5 to C6 medial branch block is not medically necessary.