

<b>Case Number:</b>	CM13-0060996		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	08/01/1992
<b>Decision Date:</b>	05/16/2014	<b>UR Denial Date:</b>	11/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/04/2013

### 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 Orthopedic Surgery and is licensed to practice in Arizona. 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 patient is a 50-year-old female who sustained a work-related injury on 8/1/92. The injury involved her left shoulder and cervical spine. The patient had an MRI of her cervical spine in 1995 which showed reversal of the normal cervical lordosis centered at C4, C5, C6, and very mild C5-C6 and C6-C7 broad based disc bulge minimal flattening of the ventricle thecal sac but no associated spinal stenosis. An electromyography (EMG) done in 1995, showed a nerve conduction slowing at the ulnar nerve across the elbows. No evidence of cervical radiculopathy. MRI of the shoulder showed mild to moderate degenerative changes of the acromioclavicular joint and fraying of the subscapularis tendon. The patient has continued to complain of cervical pain ranging between a 4-6/10. The pain is on both sides of the midline and radiates into both upper extremities. The patient has decreased cervical motion in all directions. Cervical compression produces pain in the upper extremities. The patient is described as having weakness 4/5 in both upper extremities. The C6 dermatome on the left has decreased sensation to light touch. There is pain to palpation over C 2- C3, C3- C4 and C5-C6 facet capsules bilaterally. According to UR report, the patient did undergo diagnostic blocks on the left at C2-C3 and C5-C6 on 10/1/13. The pain was apparently decreased to a level of 2/10 from a 5-6/10. Request is now made for a dorsal ramus diagnostic block on the contralateral side.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DRDB OF THE CONTRA LATERAL SIDE:** 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).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter.

**Decision rationale:** The MTUS guidelines state that invasive techniques including facet joint injections have no proven benefit in treating acute neck and upper back pain. However, many pain physicians believe a diagnostic and or therapeutic injection may help patients presenting in the transitional phase between acute and chronic pain. The Official Disability Guidelines (ODG) recommends a facet block prior to a facet neurotomy. The criterion for a successful facet block is pain relief greater than 70% for approximately 2 hours after the block. It is limited to patients with cervical pain that is non-radicular. There is documentation of failure of conservative treatment. No more than 2 levels are injected in 1 session. Recommended by them is no more than 0.5 cc of injectate. No pain medication for home should be taken for at least 4 hours prior diagnostic block and force 4-6 hours afterwards. Intravenous (IV) sedation may grant negative results of the diagnostic block. There is documentation that the patient's pain is radicular and radiates into both upper extremities. There is no documentation of the surgical procedure itself. There is no documentation of the amount of injectate. There is no documentation about when the patient took pain medication after the block. There is no documentation as to whether IV sedation was used. Although the UR note states that the patient's pain was reduced from a 5-6 to a 2; there is no documentation as to how long the pain relief lasted. The medical necessity of the procedure was not established.