

Case Number:	CM13-0064765		
Date Assigned:	01/03/2014	Date of Injury:	02/14/2004
Decision Date:	04/18/2014	UR Denial Date:	12/04/2013
Priority:	Standard	Application Received:	12/12/2013

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 Orthopaedic Surgery, has a subspecialty in Fellowship trained in Spine Surgery 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 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 49-year-old male who reported an injury on 02/13/2004. The mechanism of injury was that the patient was stepping out of a boat and slipped and fell on the concrete. Documentation submitted with the request was dated 11/06/2013. It was indicated that the patient had an epidural steroid injection and had approximately 50% relief of neck and arm symptoms and he had more relief of the neck pain than the arm pain. The patient indicated that the neck symptoms were approximately 80% of his pain. The physical examination revealed the patient had middle left axial pain. It was indicated the patient was to have rotator cuff surgery on that date of examination. The pain was constant and intermittent in the triceps into the top of the hand and fingers 4 and 5 and occurred daily but was intermittent. It was indicated that the patient had 75% strength loss since the cervical fusion of C5-6. The patient had tenderness to palpation at the facet joints above and below the fusion and midline below the fusion. The diagnoses were noted to include cervicalgia and cervical disc degeneration. The treatment plan was a medial branch block left C3 4 and C4-5 after the patient had recovered from his surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT CERVICAL MEDIAL BRANCH BLOCK C3-4, C4-5: 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): 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 was 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 pain response should be approximately 2 hours for Lidocaine...limited to no more than two levels bilaterally. Additionally, there should be documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks and the use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level, not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. The clinical documentation submitted for review failed to provide the patient had objective findings of axial neck pain, decreased range of motion and failed to indicate the patient had the absence of radicular and/or neurologic findings as the patient had generalized weakness on the left side. There was a lack of documentation of failed conservative treatment. There was a lack of documentation indicating if the request was for an initial diagnostic block or a repeat injection. Given the above, the request for outpatient left cervical medical branch block C3-4, C4-5 is not medically necessary.