

<b>Case Number:</b>	CM14-0173365		
<b>Date Assigned:</b>	10/24/2014	<b>Date of Injury:</b>	07/07/2011
<b>Decision Date:</b>	12/30/2014	<b>UR Denial Date:</b>	10/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 57-year-old male who has submitted a claim for C5-C6, C6-C7, and C7-T1 disc degeneration, C5-T1 stenosis, left C6 and C7 radiculopathy, and status post C5-T1 anterior cervical discectomy and fusion with cage and instrumentation associated with an industrial injury date of 7/7/2011. Medical records from 2014 were reviewed. The patient complained of neck pain status post discectomy and fusion, rated 8/10 in severity. Physical examination showed tenderness over the left upper cervical facet area. He likewise had bilateral occiput tenderness, left worse than the right. Extension and rotation to the left of the cervical spine triggered his cervical pain in the upper and occipital areas. MRI of the cervical spine, dated 1/16/2013, revealed moderate C5-C6 disc space narrowing, endplate changes, anterior osteophytes, and broad based disc complex, mild central canal narrowing, and non-progressive mild bilateral uncovertebral degenerative change. EMG study of bilateral upper extremities from 2/26/2014 was unremarkable. Treatment to date has included status post C5-T1 anterior cervical discectomy and fusion with cage and instrumentation on July 2014, physical therapy, and medications. The utilization review from 10/13/2014 denied the request for left cervical medial branch block - 3 medial branch blocks in a 2 month period, because the documentation provided did not identify any significant objective functional deficits to support an invasive treatment modality.

### 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 - 3 medial branch blocks in a 2 month period: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Facet Joint Diagnostic Blocks

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Facet Joint Diagnostic Blocks

**Decision rationale:** CA MTUS does not specifically address cervical medial branch blocks. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and the Official Disability Guidelines (ODG) was used instead. ODG states that medial branch blocks are not recommended except as a diagnostic tool and there is minimal evidence for treatment. While not recommended, criteria for use of medial branch blocks are as follows: there should be no evidence of radicular pain, spinal stenosis, or previous fusion; if the medial branch block is positive, the recommendation is subsequent neurotomy; there should be documentation of failure of conservative treatment prior to the procedure for at least 4-6 weeks; and no more than 2 facet joint levels are injected in one session. In this case, patient complained of neck pain status post discectomy and fusion, rated 8/10 in severity. Physical examination showed tenderness over the left upper cervical facet area. Extension and rotation to the left of the cervical spine triggered his cervical pain in the upper and occipital areas. MRI of the cervical spine, dated 1/16/2013, revealed moderate C5-C6 disc space narrowing, endplate changes, anterior osteophytes, and broad based disc complex, mild central canal narrowing, and non-progressive mild bilateral uncovertebral degenerative change. EMG study of bilateral upper extremities from 2/26/2014 was unremarkable. However, the guideline clearly states that medial branch block is not indicated if with previous fusion. Patient underwent C5-T1 anterior cervical discectomy and fusion with cage and instrumentation on July 2014. There was no discussion concerning need for variance from the guidelines. Moreover, it is not reasonable to approve 3 medial branch blocks without assessment of functional outcomes from previous block. Lastly, the present request as submitted failed to specify intended level for injection. Therefore, the request for left cervical medial branch block - 3 medial branch blocks in a 2 month period, is not medically necessary.