

<b>Case Number:</b>	CM14-0174532		
<b>Date Assigned:</b>	10/27/2014	<b>Date of Injury:</b>	10/24/2011
<b>Decision Date:</b>	12/03/2014	<b>UR Denial Date:</b>	10/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2014

### 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 Georgia. 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 72 year old presenting with an injury on 10/24/2011. The patient was treated with stretching, heat, ice, medications and home exercise program. Medication included Norco, Cyclobenzaprine and Gralise. MRI of the cervical spine on 10/03/2014 showed anterolisthesis at C3-4 and C4-5 disc space narrowing at C4-5, degenerative disc and joint disease, C5-6 disc protrusion and C5-6 and C6-7 foraminal stenosis. MRI of the right shoulder showed superior labrum anterior and posterior (SLAP) tear of the glenoid labrum, partial tear of the distal supraspinatus and infraspinatus tendons, moderate glenohumeral joint effusion and small acromioclavicular joint effusion. Electromyography (EMG) showed right carpal tunnel syndrome. The physical exam showed tenderness on palpation and muscle spasms in the cervical paraspinal muscles, limited range of motion to bilateral lateral bending and extension, slightly decreased muscle strength in the right rotator cuff muscles. The patient was diagnosed with chronic pain syndrome, cervical spondylosis and disorder of shoulder and arthropathy of cervical facet joint.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trial of cervical C4, 5, 6 bilateral medical branch block:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**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 Extremity Complaints, Treatment Considerations

**Decision rationale:** Trial of cervical C4, 5, 6 bilateral medical branch block is not medically necessary. The Occupation medicine practice guidelines criteria for use of diagnostic facet blocks require: that the clinical presentation be consistent with facet pain; Treatment is also limited to patients with back pain that is nonradicular and had no more than 2 levels bilaterally; documentation of failed conservative therapy including home exercise physical therapy and non-steroidal anti-inflammatory drug (NSAID) is required at least 4-6 weeks prior to the diagnostic facet block; no more than 2 facet joint levels are injected at one session; recommended by them of no more than 0.5 cc of injectate was given to each joint; no pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4-6 hours afterward; opioid should not be given as a sedative during the procedure; the use of IV sedation (including other agents such as modafinil) may be clouded indicate the result of the diagnostic block, and should only be given in cases of extreme anxiety; the patient should document pain relief with the management such as visual analog scale (VAS), emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity level to support subjective reports of better pain control; diagnostic blocks should not be performed in patients in whom a surgical procedure anticipated; diagnostic facet block should not be performed patients who have had a previous fusion procedure at the plan injection level. There is lack of documentation that the patient had failed an adequate trial of conservative therapy including NSAIDs and 6 weeks of physical therapy; therefore the service is not medically necessary.