

Case Number:	CM14-0020499		
Date Assigned:	04/30/2014	Date of Injury:	10/28/2011
Decision Date:	07/08/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/19/2014

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 Occupational Medicine 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 62-year-old male who was injured on 10/28/2011. He was going down metal stairs and fell down about 17 steps, resulting in injuries to his head, neck, back, both legs, and both feet. The patient's medications as of 10/19/2013 include Zofran 4 mg, Naproxen over-the-counter 200 mg, Robaxin 750 mg, Xanax 0.5 mg and Gabapentin 100 mg. The patient underwent an anterior cervical discectomy at C3-4, 4-5 with cornerstone bone grafts implanted at C3-4, 4-5 bilaterally foraminotomies C3-4, 4-5 with microdissection with a postoperative diagnosis of cervical stenosis C3-4, and 4-5 with cervical radiculopathy. MRI of the cervical spine showed no evidence of acute traumatic injury to the cervical spine, prior C5-C7 and thickening of the posterior longitudinal ligament, resulting in mild canal stenosis, and mild degenerative changes at additional levels. CT of the cervical spine with contrast dated 05/18/2012 reveals no definite clinically significant pathology. Clinic note dated 10/19/2013 indicates the patient presents with complaints of continued pain in his cervical spine which he states is present 75% of the time. It is worse with sleeping. His pain radiates to the right side of his neck up to his right temple and sometimes to the left side of his head. He rates the pain a 5/10. The pain is better with muscle relaxants and worse with moving his head. Objective findings on exam revealed a two-inch surgical scar on the anterior neck. There is pain with range of motion of the cervical spine and range of motion is decreased as well. Spurling's test was negative. Ranges of motion of the cervical spine exhibits flexion at 20 degrees; extension at 20 degrees; lateral bending at 10 degrees bilaterally; and rotation at 20 degrees bilaterally. The patient is diagnosed with cervical degenerative disk disease and cervical spondylosis with cervical facet pain, primarily right sided. Prior UR dated 02/03/2014 states the request for outpatient medical branch blocks at C3, C4, and C5 is non-certified due to insufficient evidence to support this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

OUTPATIENT MEDIAL BRANCH BLOCKS AT C3, 4, 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), Neck and Upper Back Chapter (updated 12/16/13), 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 guidelines do not address the issue in dispute and hence ODG have been consulted. The patient is a 62-year-old male with chronic neck pain and is status post C3-5 discectomy, bone graft, fusion, and bilateral foraminotomies on 5/3/12, C6-7 fusion in 2003, and prior plate instrumentation at C5-6. On a 4/13/14 qualified medical evaluation (QME) report, the patient is noted to have numbness and tingling complaints in his right index and middle fingers. Exam specifics are lacking. He is diagnosed with C3-5 radiculopathy. Several other reports that predate this request for C3-5 medial branch blocks suggest both cervical facet joint mediated pain or cervical radiculopathy. In any case, according to ODG guidelines, diagnostic facet joint blocks should not be performed in patients who have had previous fusion at the planned injection level. Medical necessity is not established.