

<b>Case Number:</b>	CM14-0032809		
<b>Date Assigned:</b>	03/21/2014	<b>Date of Injury:</b>	03/12/2013
<b>Decision Date:</b>	06/09/2014	<b>UR Denial Date:</b>	02/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/14/2014

### 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 Neurosurgery and is licensed to practice in Texas. 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 injured on 03/12/13 when he was operating a power crane resulting in pain to the neck and bilateral upper extremities. MRI of the cervical spine on 04/05/13 revealed annular bulge of the C5-6 intravertebral discs with interval development of a 3mm right lateral disc extrusion extending slightly cephalad to the intravertebral disc space level mildly flattening the anterior aspect of the cervical cord and possibly impinging on the right C6 and/or C7 nerve roots; mild central canal stenosis, slightly increased, with moderate right neuroforaminal narrowing increased; interval loss in height of the C6-7 intervertebral discs with a mild to moderate annular disc bulge with marginal osteophytic changes remained unchanged; mild central canal stenosis and change moderate bilateral neuroforaminal narrowing increased; interval development of very small central protrusion at C4-5 with mild development of central canal stenosis. The documentation indicates the patient underwent cervical epidural steroid injection on 09/24/13 which was ineffective in decreasing pain symptoms. The patient complained of neck pain that radiates to the bilateral upper extremities, left greater than right, with associated numbness and tingling and occasionally waking up with headaches. The patient reports cervical tenderness along the paraspinal muscles and bony prominence, and pain with cervical facet loading bilaterally. The patient has been deemed a non-surgical candidate at this time. Current diagnoses include cervical disc displacement without myelopathy, cervical degenerative disc disease, cervical stenosis. The clinical note dated 03/12/13 indicates the patient presented for continued complaints of neck pain that increases with extension with associated numbness in bilateral upper extremities, right greater than left. The patient reports that he will wake up at night with numbness throughout bilateral hands. The patient also reports significant tightness and soreness around his neck and shoulders. The note indicates the patient has started physical therapy, having attended 1 of 6 sessions, and is scheduled to attend once

weekly. Physical examination revealed ambulation without assistance, tenderness with palpation along the superior trapezial musculature. Current medications include Cyclobenzaprine 7.5mg BID PRN and Naproxen 550mg BID.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **BILATERAL C4-5, C5-6, C6-7 FACET INJECTIONS WITH FLUOROSCOPIC GUIDANCE AND IV SEDATION: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Facet Joint Diagnostic Blocks.

**Decision rationale:** As noted in the American College of Occupational and Environmental Medicine online version; cervical and thoracic spine disorders; radiofrequency neurotomy, neurotomy, and facet rhizotomy subset, facet joint diagnostic blocks are limited to patients with cervical pain that is non-radicular and at no more than 2 levels bilaterally. There must also be documentation of failure of conservative treatment (including home exercise, physical therapy, and NSAIDs) prior to the procedure for at least 4-6 weeks. The documentation indicates the patient started 6 sessions of physical therapy prior to 03/14/14 with no additional documentation provided to establish the efficacy of the physical therapy. The patient consistently reports neck pain with associated numbness in bilateral upper extremities. MRI also revealed central canal stenosis at multiple levels with impingement on the right C6 and/or C7 nerve roots. As such, the request for bilateral C4-5, C5-6, and C6-7 facet injections with fluoroscopic guidance and IV sedation are not recommended as medically necessary.