

Case Number:	CM15-0205887		
Date Assigned:	10/23/2015	Date of Injury:	06/26/2007
Decision Date:	12/11/2015	UR Denial Date:	09/28/2015
Priority:	Standard	Application Received:	10/20/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, California

Certification(s)/Specialty: Family Practice

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 injured worker is a 43-year-old male who sustained an industrial injury on 6-26-2007 and has been treated for neck and upper back pain. Diagnostic cervical MRI 7-7-2015 revealed degenerative disc disease at C3-4 through C6-7 and in facets at several levels, neural foraminal stenosis especially at C5-6, and left cervical spinal cord compression. On 9-17-2015 the injured worker reported 7 out of 10 pain characterized as "stabbing and prickly." Numbness was not reported. Symptoms were noted as unchanged since the last visit. No objective data was documented at this visit relating to musculoskeletal or neurological findings. A recent detailed physical examination of the cervical spine was not specified in the records specified. Documented treatment includes L5-S1 fusion 9-2009, epidural steroid injections; facet injections-medial branch blocks at unspecified levels or date; radiofrequency ablation; TENS unit, all noted to have "not helped." He has also engaged in pain-related surgery, massage therapy, yoga-medication, ice, heat, cognitive behavioral therapy, physical therapy, aquatic therapy, supervised exercise program, healing nutrition consultation, participation in a functional restoration program, muscle relaxants and narcotic pain medication, all stated as being helpful. The medication list include Lyrica, Cymbalta, Gabapentin, NSAID, Muscle relaxant and narcotics. Per the note dated 9/17/15 there was a plan for RFA (radio frequency ablation) at C4, 5 and 6. The patient had received an unspecified number of PT visits for this injury. The patient had received RFA (radio frequency ablation) and Medial branch block with benefit for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral cervical medial branch nerve block at C4, C5 and C6: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back (updated 06/25/15), Facet joint diagnostic blocks, Facet joint therapeutic steroid injections, Facet joint radiofrequency neurotomy.

Decision rationale: CA MTUS does not address facet injection. Per the ODG Neck and upper back guidelines Facet joint medial branch blocks (therapeutic injections) are "Not recommended." In addition, regarding facet joint injections, ODG states, "While not recommended, criteria for use of therapeutic intra-articular and medial branch blocks, if used anyway... There should be no evidence of radicular pain, spinal stenosis, or previous fusion." No objective data was documented relating to musculoskeletal or neurological findings. A recent detailed physical examination of the cervical spine was not specified in the records specified. A diagnostic cervical MRI dated 7-7-2015 revealed degenerative disc disease at C3-4 through C6-7 and in facets at several levels, neural foraminal stenosis especially at C5-6, and left cervical spinal cord compression. So there is a possibility of radiculopathy and spinal stenosis and the facet joint injections are not indicated when there is evidence of radicular pain and spinal stenosis. The patient had received an unspecified number of the PT visits for this injury. In addition, there was no documented evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy. The detailed response of the PT visits was not specified in the records provided. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. In addition as per cited guideline, no more than two joint level injections are to be performed at one time and this is a request for bilateral cervical medial branch nerve block at C4, C5 and C6. The medical necessity of the request for bilateral cervical medial branch nerve block at C4, C5 and C6 is not fully established in this patient.