

<b>Case Number:</b>	CM15-0112945		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	01/13/2001
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	05/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2015

### 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: Arizona, 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 74-year-old male, who sustained an industrial injury on 1/13/01. He reported pain in his neck, right shoulder and arm. The injured worker was diagnosed as having chronic region pain syndrome right upper extremity and rule out right cervical facet mediated pain. Treatment to date has included a trigger point injection on 9/9/14, a spinal cord stimulator and an occipital nerve block. On 11/11/08, the injured worker was unable to complete a radiofrequency medial branch neurotomy at C3, C4, C5 and C6 due to significant pain. Current medications include Cymbalta, Neurontin, Pantoprazole, Tramadol and Xanax. As of the PR2 dated 3/18/15, the injured worker reports right sided neck pain with radiation to the right shoulder. He uses his spinal cord stimulator during the day and turns it off at night because it is too intense when he sleeps. Objective findings include limited cervical range of motion and tenderness in the right cervical paraspinous muscles. The treating physician requested a confirmatory right cervical medial branch block at C3-C4 and C4-C5.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Confirmatory right cervical medial branch blocks, C3-4, C4-5 levels: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-neck pain and pg 26.

**Decision rationale:** According to the guidelines, Criteria for the use of diagnostic blocks for facet "mediated" pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a "sedative" during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion. In this case, the claimant had persistent pain without radicular findings. There is no plan for surgery. The diagnostic MBB of the cervical spine as above is appropriate and medically necessary.