

<b>Case Number:</b>	CM15-0178400		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	07/14/2010
<b>Decision Date:</b>	10/28/2015	<b>UR Denial Date:</b>	08/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2015

### 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 50 year old female who sustained an industrial injury on July 14, 2010. An orthopedic follow up dated March 24, 2015 reported subjective complaint of "not slept in her bed for almost a year because she cannot get the correct posture so she ends up sitting in the recliner." She further states "because of her posture in the recliner, she is getting pain in her lower back and is concerned." Previous treatment to include: diagnostic testing involving magnetic resonance imaging of cervical spine, pain consultations with injections and noted "did work for almost three weeks." She complains of being "in pain all the time and now having pain in the low back." Objective assessment noted: "right shoulder with tenderness present and able to go up to 70 degrees and then it is very painful." The left shoulder noted: "tenderness present and she can go up to 120 degrees; cannot do any overreaching." "The cervical spine is found with tenderness with an extreme amount of muscle spasms." "Neck movements are very painful and restricted." The impression reported: "right shoulder and right elbow pain, probably due to the chronic repetitive movements of the right hand, hand also a compensative mechanism due to her left shoulder injury." The plan of care is with recommendation to administer another epidural injection under consultation and prescribed Hydrocodone. The initial pain management consultation visit dated April 22, 2015 reported her "history and physical consistent with: cervical degenerative disc disease; cervical radiculopathy, and myofascial pain." The worker received a C7-T1 epidural steroid injection treating discogenic and radicular pain. She may also benefit from a course of physical therapy for exercise strengthening, stretching modalities. Primary follow up dated May 04, 2015 reported objective assessment noted: right shoulder

"she can go up to 60 degrees and then it is very painful", left shoulder "she can go up to 90 degrees and cannot do any overreaching", cervical spine with "an extreme amount of muscle spasms, neck movements are very painful and restricted." On May 06, 2015 she underwent administration of cervical epidural steroid injection. Primary follow up dated June 01, 2015 reported the worker status post injection with subjective complaint of: has "a lot of neck pain and the shoulder pain": "injection really helped": "It helped me more than 25% and numbness in the left arm is much improved." She is requesting another consultation to obtain a repeat injection for the neck. The patient sustained the injury due to cumulative trauma. The medication list include hydrocodone, Xanax and Mobic. Per the note dated 8/12/15 the patient had complaints of pain in neck with radiation in left shoulder and upper back at 6/10. Physical examination of the neck and upper back revealed tenderness on palpation and positive Neer and Hawkin sign and painful ROM. The patient's surgical history include right shoulder surgery on 12/29/11. The patient had received an unspecified number of the PT visits for this injury. Patient had received cervical ESI for this injury. The patient has had MRI of the cervical spine on 8/3/12 that revealed disc protrusions, foraminal narrowing, and degenerative changes.

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

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

**Left C3, C4, and C5 medial branch block:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Neck & Upper Back (updated 06/25/15), Facet joint diagnostic blocks.

**Decision rationale:** Request: Left C3, C4, and C5 medial branch block. Per the cited guidelines "Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints, 2 or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms." Per the ODG guidelines, Facet joint diagnostic blocks are "Recommended prior to facet neurotomy (a procedure that is considered "under study"). Criteria for the use of diagnostic blocks for facet nerve 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 be approximately 2 hours for Lidocaine. 2. Limited to patients with cervical 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. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. 12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment." Per the note dated 8/12/15 the patient had complaints of pain in neck with radiation in left shoulder and upper back at 6/10. The patient had

received a cervical ESI for this injury and the patient has had diagnosis of cervical radiculopathy. The cited guidelines do not recommended facet block for patient with radicular pain. 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 patient had received an unspecified number of the PT visits for this injury. The detailed response of the PT visits was not specified in the records provided. Previous conservative therapy notes were not specified in the records provided. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. Failure to previous conservative therapy including physical therapy visits and pharmacotherapy is not specified in the records provided. The medical necessity of left C3, C4, and C5 medial branch block is not fully established for this patient at this juncture. Therefore, the request is not medically necessary.