

Case Number:	CM15-0096791		
Date Assigned:	05/27/2015	Date of Injury:	12/06/2005
Decision Date:	06/30/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/19/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 60-year-old male who sustained a work related injury December 6, 2005. Past history included s/p C6-C7 fusion without hardware 1989, s/p microlumbar decompressive surgery L2-S1, 2008, s/p microlumbar decompressive surgery left L2-L3 January, 2013, and s/p two left shoulder surgeries. According to a primary treating physician's progress report, dated April 3, 2015, the injured worker presented for follow-up of neck pain, rated 8/10, and back pain, rated 8-9/10. He reports his low back pain is worse on the right side and continues to be severe at times. He also complains of persistent pain in the right shoulder and bilateral knee. An MRI of the lumbar spine was performed March 26, 2015. Objective findings included; gait mildly antalgic, pain with facet loading of the cervical spine and lumbar spine, decreased sensation L3-L5 dermatomes on the left, straight leg raise on the left at 40 degrees causes radiation of pain down to foot, straight leg raise on the right at 60 degrees causes radiation of pain down the right leg to foot, some palpation tenderness over the left plantar fascia. Diagnoses are pseudoarthrosis C6-C7; myelopathy; multilevel disc herniation of the cervical spine with moderate to severe neural foraminal narrowing; failed back syndrome; multilevel disc herniation of the thoracic and lumbar spines; facetogenic neck pain. At issue, is the request for authorization for bilateral medial branch block.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral medial branch block C4-C5 AND C5-C6: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper Back Chapter, under Facet joint diagnostic blocks.

Decision rationale: The patient presents on 04/03/15 with neck pain rated 8/10, and lower back pain rated 8-9/10, worse on the right side. The lumbar pain radiates into the bilateral lower extremities, left worse than right, and the cervical pain radiates into the bilateral upper extremities, right worse than left. The patient also reports numbness and tingling in the bilateral upper extremities. The patient's date of injury is 12/06/05. Patient is status post C6-C7 fusion in 1989, microlumbar decompression surgery at L2-S1 levels in 2008 and at L2-L3 levels on 01/03/13. The request is for BILATERAL MEDIAL BRANCH BLOCK C4-5/C5-6. The RFA is dated 04/03/15. Physical examination dated 04/03/15 reveals pain elicitation on facet loading maneuvers of the cervical spine, intact upper extremity sensation, and limited shoulder range of motion secondary to pain. Neurological examination of the lower extremities reveals decreased sensation along the L3, L4, and L5 dermatomes on the left, and positive straight leg raise bilaterally (40 degrees on the left, 60 degrees on the right). The patient's current medication regimen is not provided. Diagnostic imaging included cervical MRI dated 05/08/13, significant findings include: "Degenerative disc disease and facet arthropathy with degenerative disc disease also noted in the proximal thoracic spine with focal protrusion/extrusion C2-3, C3-4, C4-5. Canal stenosis includes C3-4 mild, C4-5 mild to moderate, C5-6 mild to moderate, C6-7 mild to moderate, C7-T1 mild to moderate stenosis. Neural foraminal narrowing includes C3-4 severe left, moderate right, C4-5 severe left, moderate to severe right; C5-6 severe bilateral, C6-7 moderate right, severe left, C7-T1 moderate right neural foraminal narrowing." Patient is currently classified as permanent and stationary, though current work status is not specified. MTUS/ACOEM Neck Complaints, Chapter 8, page 174-175, under Initial Care states: for Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints, or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injections may help patients presenting in the transitional phase between acute and chronic pain. ODG-TWC, Neck and Upper Back Chapter, under Facet joint diagnostic blocks states: "Recommended prior to facet neurotomy - a procedure that is considered "under study". Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block - MBB. 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. 4. No more than 2 joint levels are injected in one session. For facet joint pain signs and symptoms, the ODG guidelines state that physical examination findings are generally described as: "1. axial pain, either with no radiation or severity past the shoulders; 2. tenderness to palpation in the paravertebral areas, over the facet region; 3. decreased range of motion, particularly with extension and rotation; and 4. absence of radicular and/or neurologic findings." In regard to the request for a diagnostic cervical medial

branch block, the patient does not meet guideline criteria. There is no evidence that this patient has not had any medial branch blocks to date, nor is he anticipating surgery. The requested number of levels is appropriate, and there is documentation of a failure of conservative therapies to date. However, per progress note dated 04/03/15, this patient presents with significant radicular symptoms in the bilateral upper extremities. While neurological function in the bilateral upper extremities is otherwise intact, the presence of radicular symptoms precludes a medial branch block at the requested levels. Guidelines require a lack of radicular pain in the upper extremities prior to a diagnostic cervical medial branch block, given the information provided such a block cannot be substantiated. Therefore, the request IS NOT medically necessary.