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| Case Number: | CM13-0065445 | | |
| Date Assigned: | 01/03/2014 | Date of Injury: | 04/04/2007 |
| Decision Date: | 05/16/2014 | UR Denial Date: | 11/25/2013 |
| Priority: | Standard | Application Received: | 12/13/2013 |

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 54 year-old male who was injured on 4/4/2007. He has been diagnosed with right hip greater trochanteric bursitis; depression; chronic pain; right sacroiliac joint sprain; low back pain; facet arthropathy; uncontrolled diabetes type 2; cervical spinal stenosis; right shoulder pain; thoracic pain; neck pain; cervical degenerative disc disease; carpal tunnel syndrome; radiculopathy thoracic or lumbar; right rotator cuff repair. According to the 8/27/13 anesthesiology/pain management report from [REDACTED], the patient presents with moderatesevere low back, gluteal and neck pain. Exam shows palpatory tenderness at the right greater trochanteric bursa, SI joint, PSIS, iliotibial band and neck. There was positive facet loading bilaterally. The physician ordered medial branch nerve blocks for the cervical spine, right and left C2, C3 and 3rd occipital nerve and for the sacrum at L5, S1, S2 and S3 on the right side. UR denied these on 11/25/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 RIGHT SIDED CERVICAL MEDIAL BRANCH NERVE BLOCK AT C2, C3, TON: Overturned

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 Page(s): 174-175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: According to the MTUS/ACOEM guidelines, "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." According to the Official Disability Guidelines (ODG), regarding the criteria for medial branch blocks, "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 $\geq 70\%$. 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 (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy. 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 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. 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." Based on the medical records provided for review the patient reported moderate to severe neck and back pain. Examination showed palpatory tenderness over the cervical paraspinals/facets, and facet loading tests were positive. The request was to block the C2/3 level by doing the C2, C3 medial branches and the 3rd occipital nerve. [REDACTED] did the right-side on 10/2/13 and the left on 11/4/13. The request is in accordance with Official Disability Guidelines. The request for 1 right sided cerv

1 LEFT SIDED CERVICAL MEDIAL BRANCH NERVE BLOCK C2, C3, TON:
Overturned

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 Page(s): 174-175.

Decision rationale: According to the MTUS/ACOEM guidelines, "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." According to the Official Disability Guidelines (ODG), regarding the criteria for medial branch blocks, "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 $\geq 70\%$. 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 (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy. 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 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. 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." The patient reported moderate to severe neck and back pain. exam showed palpatory tenderness over the cervical paraspinals/facets, and facet loading tests were positive. The request was to block the C2/3 level by doing the C2, C3 medial branches and the 3rd occipital nerve. [REDACTED] did the right-side on 10/2/13 and the left on 11/4/13. The request is in accordance with Official Disability Guidelines (ODG). The request for 1 left sided cervical medial branch nerve block at C2, C3, TON, is medic

1 SACRAL MEDIAL BRANCH NERVE BLOCK L5, S1, S2, S3 ON RIGHT SIDE:

Overtured

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 300-301.

Decision rationale: MTUS/ACOEM did not mention the SI joint, so Official Disability Guidelines (ODG) were consulted. ODG guidelines state there should be at least 3 exam tests for the SI joint and failure of conservative care. Based on the medical records provided for review the patient reported moderate to severe neck and back pain. Examination showed palpatory

tenderness over the cervical paraspinals/facets, and facet loading tests were positive. [REDACTED] also states that Gaenslans, Shear and Faberes were positive on the right. The request sacral medial branch nerve block L5, S1, S2, S3 on the right side is medically necessary and appropriate.