

<b>Case Number:</b>	CM14-0164930		
<b>Date Assigned:</b>	10/10/2014	<b>Date of Injury:</b>	03/01/2001
<b>Decision Date:</b>	11/17/2014	<b>UR Denial Date:</b>	09/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2014

### 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 and is licensed to practice in Georgia. 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 62-year-old female who was injured on 03/01/2001. The mechanism of injury is unknown. She has been treated conservatively with 24 weeks of chiropractic treatment. Prior medications have included Percocet, Norco, Naproxen, Gabapentin, LidoPro cream, Flexeril, Soma; Prior surgical history includes Posterior Lumbar Interbody Fusion at L4-L5 on 03/19/2013 and fusion of C4-C5, C5-C6, and C6-C7 on 08/16/2011. Progress report dated 08/12/2014 noted the patient reported 2/10 pain in her neck, with no left sided neck pain and 95% relief of right sided neck pain. She was able to decrease her Norco usage. She reported continued numbness in her hand with a distribution reportedly consistent with carpal tunnel syndrome and non-dermatomal. The note documented continued severe restriction of cervical range of motion in all planes due to pain. Sensation was objectively intact in her upper extremities, and her strength was reportedly 5-/5 throughout her upper limbs. Progress report dated 09/30/2014 indicated the patient presented with neck, back and right lower extremity pain. She had a medial branch block on 07/25/2014 and reported 2 weeks of relief. She reported with her medications her pain is a 10/10 and without them, her pain is 4-5/10. On exam, she had decreased flexion and extension of the lumbar spine. She had decreased range of motion in all planes in her cervical spine, which was severely limited secondary to pain. The patient was diagnosed with lumbar spondylosis, status post C4-C7 fusion, status post posterior lumbar interbody fusion at L4-L5 on 03/19/2013 and chronic pain syndrome. A request was placed for bilateral intra-articular facet joint injection at C7-T1 as she had previous relief with a medial branch block, with an expectation to improve her function. Prior utilization review dated 09/26/2014 stated the request for Bilateral Intra-Articular Facet Joint Injection at C7/T1 is not certified, as the patient was not a candidate for an injection.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Bilateral Intra-Articular Facet Joint Injection at C7/T1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Neck and Upper Back, Facet Joint Diagnostic Blocks & Facet Joint Therapeutic Steroid Injections

**Decision rationale:** The American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) notes that facet injection of corticosteroids is not recommended as a treatment for neck pain. Per the Official Disability Guidelines (ODG), facet joint injections are performed with a diagnostic purpose primarily, with the intent of proceeding to facet neurotomy at the diagnostic levels if successful. Facet diagnostic blocks of the medial branch nerves have been found to have better predictive effect than facet intra-articular injections with corticosteroids. One set of diagnostic medial branch blocks (MBB) performed on an individual with clinical presentation of facet pain is recommended. A positive result is greater than or equal to 70% response rate, with approximately 2-hours of pain relief for a Lidocaine injection. Injections should be limited to patients with non-radicular cervical pain, performed at no more than two levels bilaterally. They should only be performed after there has been a documented failure of conservative treatment. No more than two joint-levels should be injected in one session. The medical records indicate the patient reported 2-weeks of relief of her pain from diagnostic medial branch blocks with 1% Lidocaine. This is considered nondiagnostic, as criteria dictate the patient should only receive approximately 2-hours of relief from injections in order to be able to attribute symptom relief to the injections themselves. As the medial branch nerves innervate the facet joints, facet capsular ligaments, interspinous and supraspinous ligaments, spinous processes, and paraspinal muscles, there is no reason to presume an intra-articular injection would be more effective or diagnostic of facet-mediated disease than a medial branch block. Based on the ACOEM and ODG guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.