

Case Number:	CM14-0168548		
Date Assigned:	10/16/2014	Date of Injury:	02/13/2012
Decision Date:	11/19/2014	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	10/13/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 60-year-old woman who sustained a work-related injury on February 15, 2012. Subsequently she developed chronic neck pain. A progress report dated on August 29, 2014 stated the patient was complaining of neck pain, headaches, visual changes and bilateral radicular arm pain. The physical examination demonstrated cervical tenderness with reduced range of motion and reduced sensation in the territory of right C6-C7 dermatoma. A cervical MRI performed on February 7, 2014 demonstrated moderate to severe right foraminal stenosis at C3-C4, mild tenderness facet AT C5-6 and 3 mm protrusion with mild bilateral foraminal stenosis at C6-C7. The provider requested authorization for C6-7 bilateral facet joint injection and C6 T1 intralaminar epidural injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 C6-7 bilateral facet joint injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-5. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 309,181.

Decision rationale: According MTUS guidelines, <Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain>. According to ODG guidelines regarding facets injections, < Under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti, 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial.>. Furthermore and according to ODG guidelines, < Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: 1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion.3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time.5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. In this case, there is no documentation of facet mediated pain. There is no clear evidence or documentation that C6-7 facets are the main pain generator. There is no evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. According to MTUS guidelines, facet injection is not recommended for neck and upper back complaints. Therefore, the request for C6-7 bilateral facet joint injection is not medically necessary.

1 C6-T1 intralaminar epidural injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

Decision rationale: According to MTUS guidelines, cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. Epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit; however there is no significant

long term benefit or reduction for the need of surgery. The patient file does not document that the patient is a candidate for surgery. Furthermore, there is no recent clinical and objective documentation of radiculopathy. MTUS guidelines do not recommend epidural injections for neck pain without radiculopathy. Furthermore, the injection of no more than 2 levels is recommended. Therefore, the request for C6-T1 intralaminar epidural injection is not medically necessary.