

<b>Case Number:</b>	CM14-0035026		
<b>Date Assigned:</b>	03/24/2014	<b>Date of Injury:</b>	06/11/2009
<b>Decision Date:</b>	12/31/2014	<b>UR Denial Date:</b>	03/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/21/2014

### 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 Orthopedic Surgeon, has a subspecialty in Spine Surgeon 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 injured worker is a 51-year-old male who reported an injury on 06/11/2009. The mechanism of injury was the injured worker tripped and fell carrying a box and experienced pain predominantly in the neck, upper back, and right arm. Prior treatments and studies included x-rays, medications, physical therapy, a TENS unit cervical MRI and EMG, and an epidural steroid injection. The injured worker's current medications included tramadol and tizanidine. The surgical history was not provided. The injured worker underwent an EMG/NCV of the bilateral upper extremities on 10/18/2013 which revealed a normal electromyogram of the bilateral upper extremities, normal motor and sensory conduction study of the upper extremities, and no evidence of cervical radiculopathy, brachial plexopathy, carpal tunnel syndrome, cubital tunnel syndrome, or generalized polyneuropathy. The neurologic examination revealed no significant objective abnormality. The documentation of 12/19/2013 revealed the injured worker had a soft tissue process involving the musculature about the neck and shoulder girdle. The physician had opined there was not a cervical radiculopathy. The documentation indicated the injured worker did not have the picture of facetogenic pain. There was no Request for Authorization, requested date of treatment, or physician documentation requesting the intervention.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical facets to bilateral C5-C7 under fluoroscopic and conscious sedation:** Upheld

**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): 175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Criteria for the use of diagnostic blocks for facet nerve pain

**Decision rationale:** The American College of Occupational and Environmental Medicine guidelines indicate that diagnostic facet joints 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. As such, applications of secondary guidelines were sought. Per Official Disability Guidelines criteria for the use of diagnostic blocks for facet nerve pain include "clinical presentation should be consistent with facet joint pain, signs and symptoms which include unilateral pain that does not radiate past the shoulder, objective findings of axial neck pain (either with no radiation or rarely past the shoulders), tenderness to palpation in the paravertebral areas (over the facet region); a decreased range of motion (particularly with extension and rotation) and the absence of radicular and/or neurologic findings. If radiation to the shoulder is noted pathology in this region should be excluded. There should be one set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine...limited to no more than two levels bilaterally. Additionally, there should be documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks and 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... Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated... Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level... 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 clinical documentation submitted for review failed to provide a recent objective physical examination. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations, as the use of IV sedation may be grounds to negate the results of a diagnostic block and should be given only in cases of extreme anxiety. Given the above and the lack of documentation, the request for cervical facets to bilateral C5-C7 under fluoroscopic and conscious sedation is not medically necessary.