

<b>Case Number:</b>	CM14-0036279		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	05/18/1994
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	02/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/25/2014

### 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 Family Medicine 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 44 year-old man who was injured at work on 05/18/1994. The injury was primarily to his back and neck. He is requesting review of denial for a bilateral medial branch nerve radiofrequency neurotomy at C3, C4, and C5, and for psyllium fiber 0.52 grams. The medical records corroborate ongoing care for these injuries. These records include entries from [REDACTED]; the source of the request for the neurotomy and the prescription for psyllium. The providers document the following chronic medical problems: Neck Pain; C5-C7 Level with Central Cord Syndrome; Low Back Pain; Failed Back Surgery Syndrome (Cervical); Degenerative Disc Disease (Lumbar); Sacroiliitis; Chronic Pain; and Constipation. His last reported MRI was notable for the following: Lumbar Spondylosis with Degenerative Joint Disease; Degenerative Disc Disease; Facet Arthropathy with Sacroiliitis. Treatment has included injections into the sacroiliac joint and radiofrequency cervical medial branch neurotomy at different cervical levels in the treatment of the patient's persistent pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Medial Branch Nerve RadioFrequency Neurotomy at C3, C4, and C5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Occupational Disorders of the Neck and Upper Back, Radiofrequency Neurotomy.

**Decision rationale:** The patient is a 44 year-old man who was injured at work on 05/18/1994. The injury was primarily to his back and neck. He is requesting review of denial for a bilateral medial branch nerve radiofrequency neurotomy at C3, C4, and C5, and for psyllium fiber 0.52 grams. The medical records corroborate ongoing care for these injuries. These records include entries from [REDACTED]; the source of the request for the neurotomy and the prescription for psyllium. The providers document the following chronic medical problems: Neck Pain; C5-C7 Level with Central Cord Syndrome; Low Back Pain; Failed Back Surgery Syndrome (Cervical); Degenerative Disc Disease (Lumbar); Sacroiliitis; Chronic Pain; and Constipation. His last reported MRI was notable for the following: Lumbar Spondylosis with Degenerative Joint Disease; De The Official Disability Guidelines comment on the use of radiofrequency neurotomy. These guidelines recommend that prior to facet neurotomy (a procedure that is considered "under study") that 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). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBB. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 27% to 63%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. Technique: The described technique of blocking the medial branch nerves in the C3-C7 region (C3-4, C4-5, C5-6, and C6-7) is to block the named medial branch nerves (two injections). Authors have described blocking C2-3 by blocking the 3rd occipital nerve. Another technique of blocking C2-3 is to block at three injection points (vertically over the joint line, immediately above the inferior articular facet at C2 and immediately below the superior articular facet at C3). (Barnsley, 1993) The medial branch nerve innervates the facet joint, facet capsular ligaments, the interspinous and supraspinous ligaments, spinous processes and paraspinal muscles. Relief of pain could be due to blockade of nociceptive input from any combination of these. It is suggested that the volume of injectate for diagnostic medial branch blocks be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate) as increased volume may anesthetize these other potential areas of pain generation and confound the ability of the block to accurately diagnose facet pathology. A recent study has recommended that the volume be limited to 0.25 cc. Epidemiology of involved levels: Using cadaver evidence facet arthrosis most commonly affects the upper cervical levels, and increased with age, and was very rare in patients less than 40 years of age. C4-5 is the most common level followed by C3-4 and C2-3. This study did not attempt to identify number of levels of involvement. (Lee, 2009) Number of levels of involvement: In a randomized controlled trial of therapeutic cervical medial branch blocks it was stated that 48% of patients had 2 joints involved and 52% had three joints involved. (Manchikanti, 2008) These levels were identified by the pain pattern, local or paramedian tenderness over the area of the facet joint, and reproduction of pain to deep pressure. (Manchikanti, 2004) Other prevalence studies from this group also indicated that the majority of

patients with cervical involvement were treated at three joints. Target joints were identified as noted above. (Manchikanti, 2004). There are no studies that have actually tested levels of involvement using individual injections for diagnostic verification. 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 (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 information available in the records, the examination findings repeatedly indicate that this patient is experiencing pain at the C6-7 and C7-T1 levels; yet the request is for radiofrequency neurotomy at the C3, C4, and C5 levels. Further, prior injections have demonstrated a 50-80 percent in pain; however, the levels that were injected with C6-7 and C7-T1. Therefore the patient does not meet elements of the above stated criteria to include: failure to demonstrate greater than or equal to 70% reduction of pain relief at the same level that is proposed for the neurotomy, lack of a diagnostic medial branch block at the level proposed and treating more than 2 levels in one session. For these reasons, the proposed treatment is not considered as medically necessary. Generative Disc Disease; Facet Arthropathy with Sacroiliitis. Treatment has included injections into the sacroiliac joint and radiofrequency cervical medial branch neurotomy at different cervical levels in the treatment of the patient's persistent pain.

**Psyllium Fiber 0.52gm #180:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Management of Opioid Therapy for Chronic Pain working Group. Pg 159.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** The ACOEM, the MTUS/Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines do not comment on the treatment of psyllium fiber for

constipation. Further, in reviewing the available medical records, no specific information is available on the nature or duration of the constipation, whether the patient has undergone a prior evaluation for this problem, and the response to treatment with psyllium fiber to date. For example, the problem list includes the diagnoses: 564.00 (Constipation) and 564.00 (Constipation, Unspecified). The only notations on symptoms of the gastrointestinal tract are in the Review of Symptoms Section and are positive for the following: Abdominal Pain, Blood in Stool, Change in Stool Pattern, Constipation, and Heartburn. Given the insufficient documentation on the nature of this problem it cannot be determined whether treatment with psyllium is appropriate. Therefore, the request for psyllium is not considered as medically necessary.