

Case Number:	CM14-0176748		
Date Assigned:	10/30/2014	Date of Injury:	07/05/2012
Decision Date:	01/06/2015	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	10/24/2014

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 57-year-old woman who sustained a work-related injury on July 5, 2012. Subsequently, she developed chronic neck and right knee pain. Physical therapy, cortisone injections, medications, and activity adjustments in the past have provided symptomatic relief. An EMG report dated September 15, 2014 showed bilateral C6 radiculitis and moderate bilateral carpal tunnel syndrome. The cervical spine MRI done on June 6, 2014 showed early degenerative disc disease at 3-4 through C6-7. There was minimal posterior bulging of the discs at C3-4 through C6-7, which do not contact the underlying spinal cord. According to the progress report dated October 14, 2014, the patient described her pain as aching over the left side of her head, neck, left trap, left shoulder, and left upper arm as well as her right knee. She rated her pain as an 8/10 without medications and 7/10 with medications. Examination of the cervical spine revealed tenderness over the cervical paraspinals on the left and left trap, tenderness over the facets joints. There was limited flexion and lateral bending bilaterally due to increased pain. Flexion and extension were within normal limits. Hoffman's sign was negative bilaterally. Spurling's sign was negative. Examination of the bilateral knees revealed tenderness to palpation of the proximal right knee as well as the medial and lateral joint line. There was no tenderness to palpation of the left knee. Range of motion with the right knee had slight decrease with extension. Flexion was full. Left knee range of motion was full. There was positive crepitus bilaterally. The patient was diagnosed with right knee pain, right knee chondroplasty of the patella, neck pain, cervical facet pain, cervical discogenic pain, cervical radiculitis, chronic pain syndrome, bilateral carpal tunnel syndrome, myofascial pain, and depression due to chronic pain. The provider requested authorization for Cervical Facet Joint Injection C2-3, C5-6, and C6-7 on left side using fluoroscopic guidance and conscious sedation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Facet Joint Injection C2-3, C5-6, C6-7 on left side under fluoroscopic guidance and conscious sedation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Facet Joint Intra-Articular Injections (Therapeutic Blocks) (http://worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#Facetjointinjections).

Decision rationale: According to 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 facet 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 concert 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, 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. The ODG guidelines did not support facet injection for cervical pain in this context. There is no strong evidence supporting the use of cervical facet injection for the treatment of neck pain. There is no documentation that the cervical facets are the main pain generator. There is no documentation of a formal rehabilitation plan that will be used in addition to facet injections. Furthermore, there is no documentation of rationale behind the request for cervical facet block and whether this is used

for diagnostic and therapeutic purpose. Therefore, Cervical Facet Joint Injection C2-3, C5-6, C6-7 on left side using fluoroscopic guidance and conscious sedation is not medically necessary.