

Case Number:	CM14-0187888		
Date Assigned:	11/18/2014	Date of Injury:	08/23/2011
Decision Date:	01/07/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	11/11/2014

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 37-year-old injured worker who sustained a work-related injury on August 23, 2011. Subsequently, the patient developed chronic neck pain. Cervical MRI of November 3, 2012 demonstrated: C4-5 congenital vertebral fusion and levoscoliosis, C6-7 multifactorial mild central canal stenosis with left lateral recess narrowing and mild bilateral neural foraminal stenosis, multifactorial mild central canal stenosis and mild bilateral neural foraminal narrowing, C3-4 degenerative changes without canal stenosis or neural foraminal narrowing, and C7-T1 mild left neural foraminal stenosis. Prior treatments included: physical therapy, ice, heat, bed rest, medications, and TENS. According to a progress report dated September 24, 2014, the patient had pain in bilateral neck 90% with radiation to bilateral arm to the lateral 3d finger. The patient also reported occipital that was closely associated with flare up in neck pain. The pain was described as shooting, stabbing, leaning, aching, constant, and intermittent. The pain was rated at 9/10 as worst and 4/10 as the usual. On examination, the gait was non-antalgic and the patient was able to heel-and-toe walk normally. The shoulders were level and the iliac crest was level. There was no scoliosis and normal thoracic spine convexity. There was normal lumbar curve. Examination of the cervical spine revealed mild spasm and tenderness to the facet and paracervical. The paraspinous muscle tone was normal. The upper peripheral vascular pulses were normal. On facet loading, there were positive results on the left and right. The muscle strength was 5/5 in all major muscle groups. There was normal reflexes and distal sensation. The sensation was intact to light touch. The Spurling's test was guarded on the right and left. The shoulder abduction and Adson's test were negative bilaterally. The drop arm and Neer tests were negative. The patient was diagnosed with cervical radiculopathy, neuritis and stenosis, spondylosis without myelopathy, and cervical spine degenerative disc disease. The provider requested authorization for Right C3-C5 medial branch blocks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right C3-C5 medial branch blocks mod sedation at the cervical spine: 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), facet joint blocks

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 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. 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. The ODG guidelines did not support facet injection for cervical pain in this clinical context. There is no documentation of facet mediated pain or that facets are the main pain generator. There is no documentation of failure of conservative therapies in this patient. No more than 2 level facet injections at one session are authorized by the guidelines. Therefore, the request for Right C3-C5 medial branch blocks is not medically necessary.