

<b>Case Number:</b>	CM14-0197228		
<b>Date Assigned:</b>	12/05/2014	<b>Date of Injury:</b>	07/13/2004
<b>Decision Date:</b>	01/16/2015	<b>UR Denial Date:</b>	10/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/24/2014

### 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 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 52 year-old woman who was injured at work on 7/13/2004. The injury was primarily to her neck. She is requesting review of denial for the following: Cervical Facet Blocks at C5-6 & C6-7 at the [REDACTED] Medical records corroborate ongoing care for her injuries. These records include her Primary Treating Physician's Profess Reports. At her last documented visit on 10/1/2014 the patient described moderate, constant cervical pain. Physical examination was performed and was notable for: cervical spine tenderness to palpation with "less spasm today." There was tenderness to palpation over the right trapezius and central paraspinal muscles with "spasms appreciated." A CT scan of the neck was performed on 9/11/2014. It revealed the following findings: Prior anterior discectomies and fusion at C3-C7. Satisfactory postoperative appearance with intact hardware and satisfactory alignment at the operative levels. There is a mild degree of congenital spinal canal stenosis at these levels. Moderate degenerative changes at C7-T1 with minimal C7 on T1 anterolisthesis. Moderate left foraminal stenosis at this level may potentially compress the existing left C8 nerve root. At C3-4 uncovertebral hypertrophy causes moderate left foraminal stenosis, potentially compressing the exiting left C4 nerve root. EMG demonstrated a chronic left C7 radiculopathy. The diagnoses include: Lumbar HNP at L5/S1; Cervical Spondylosis; Carpal Tunnel Syndrome; and Left Shoulder Joint Disease. She was treated with a combination of Flexeril, Norco, Prilosec, Neurontin, Soma and Flurbi Cream. A cervical facet block was requested at this visit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical facet blocks at C5-6 & C6-7 at [REDACTED]: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back/Acute and Chronic, Facet Joint Pain/Signs and Symptoms; Facet Joint Diagnostic Blocks.

**Decision rationale:** The Official Disability Guidelines (ODG) comment on the signs and symptoms of facet joint pain as well as the indications for facet joint blocks. Regarding facet joint pain/signs and symptoms, the ODG state the following: The cause of this condition is largely unknown although pain is generally thought to be secondary to either trauma or a degenerative process. Traumatic causes include fracture and/or dislocation injuries and whiplash injuries, with the most common cervical levels involved in the latter at C2-3 and C5-6. The condition has been described as both acute and chronic, and includes symptoms of neck pain, headache, shoulder pain, suprascapular pain, scapular pain, and upper arm pain. Symptoms: The most common symptom is unilateral pain that does not radiate past the shoulder. Physical findings: Signs in the cervical region are similar to those found with spinal stenosis, cervical strain, and diskogenic pain. Characteristics are generally described as the following: (1) axial neck pain (either with no radiation or rarely past the shoulders); (2) tenderness to palpation in the paravertebral areas (over the facet region); (3) decreased range of motion (particularly with extension and rotation); & (4) absence of radicular and/or neurologic findings. If radiation to the shoulder is noted pathology in this region should be excluded. Diagnosis: There is no current proof of a relationship between radiologic findings and pain symptoms. The primary reason for imaging studies is to rule out a neurological etiology of pain symptoms. Diagnosis is recommended with a medial branch block at the level of the presumed pain generator/s. Regarding the use of facet joint blocks, the ODG state the following: Recommended prior to facet neurotomy (a procedure that is considered "under study"). 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). 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.

**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. 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. 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. 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.

In this case in the utilization review process there was insufficient information to determine whether the patient met the ODG stated criteria for the signs and symptoms of facet joint pain. Further, it is unclear whether the patient meets the criteria for the use of diagnostic blocks. This includes a proposed treatment at the sight of a previous fusion procedure and pain that appears to have a radicular component. Under these conditions, the use of cervical facet blocks at C5-6 and C6-7 are not considered as medically necessary.