

Case Number:	CM14-0203277		
Date Assigned:	12/15/2014	Date of Injury:	09/24/1992
Decision Date:	02/09/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	12/04/2014

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 Anesthesiology, has a subspecialty in Acupuncture & Pain 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 injured worker is a 64 year old male with a date of injury 9/24/1992 from a branch that weighed approximately 300 pounds fell on him causing neck and low back injury. The injured worker received radiology testing, diagnostic testing, chiropractic treatment, holistic treatment, medication management, injections, follow visits with spinal specialists. The injured workers diagnosis was cervical Stenosis, headaches, chronic back and neck pain, cervical arthrodesis C3-C5, congenital spondylolisthesis, degenerative disc disease, cervical spondylosis without myelopathy and status post cervical branch neurotomy on 12/19/2012 and 9/18/2013. The follow up MD visit on 8/19/2014 the injured worker continued with chronic cervical and axial pain below the cervical fusion. The last neurotomy was status post 11 months ago and the injured worker had 80-85% relief following the neurotomy. The plan was to repeat the medical branch neurotomy. On 10/31/2014 Utilization Review non-certified for 1 Diagnostic Bilateral Cervical C2-C3 Medial Branch Block ACOEM Guidelines, Medial Branch Block: The guidelines do not recommend diagnostic blocks for neck and upper back complaints the guideline also do not recommend them for bilateral axial pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Diagnostic Bilateral Cervical C2-C3 Medial Branch Block: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

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, Facet Joint Diagnostic Blocks (Injections).

Decision rationale: Per the ODG guidelines, facet joint medial branch blocks are not recommended except as a diagnostic tool, citing minimal evidence for treatment. The ODG indicates that criteria for facet joint diagnostic blocks (injections) are as follows: 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back 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 facet 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. 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 (including other agents such as midazolam) 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. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)] The documentation submitted for review indicates that the injured worker has gone through this procedure twice already and that it has provided 85% relief. Per the documentation reviewed, I respectfully disagree with the UR physician's assertion that the requested MBBs are at levels already fused; fusion was at other levels. Therefore, the request is medically necessary.