

Case Number:	CM14-0217776		
Date Assigned:	01/07/2015	Date of Injury:	03/01/2013
Decision Date:	02/28/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	12/29/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials: State(s) of Licensure:
California Certification(s)/Specialty:
Internal Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 57 year old female sustained an industrial related injury on 03/01/2013. The results of the injury and initial diagnoses were not provided. Per the primary treating physician's progress report (PR) (12/03/2014), the injured worker's subjective complaints included triggering of the right third finger with discomfort, near triggering of the right index finger with pain in the volar aspect, mild tenderness in the left thumb metacarpophalangeal (MP) joint on the volar aspect, weakness in her grip resulting in dropping things, pain in the right elbow, posterior neck pain with stiffness, and upper back discomfort. Objective findings on this report included: tenderness to the neck musculature extending into the upper back as well as far inferiorly as the superior aspects of the scapulae bilaterally; tenderness to palpation over the right lateral epicondyle which appeared to be mild with provocative testing including strong grip as well as resistance to dorsiflexion of the wrist and resistance to the digit extension causing some minor injuries and discomfort to the right lateral elbow; triggering of the right third finger; tenderness to palpation (right second finger) in the distal palm proximal to these two digits; decreased grip strength in the right hand when compared with the left; and mildly positive Tinel's and Durkan's compression tests. The secondary treating physician's progress report (12/10/2014) cervical exam findings showed: flexion of 75%, extension of 75%, right lateral bend of 50%, left lateral bend of 75%, right rotation of 75%, and left rotation of 75%. Spasms were positive over the right greater than the left cervical paraspinals, trapezius, levator scapulae, rhomboids, sternocleidomastoid muscles. Axial compression of the cervical spine relates to concordant pain on the right side and neck and periscapular region. Treatment to date has included occupational/physical therapy,

acupuncture, injections to the left carpal tunnel and volar aspect of the left thumb (01/07/2013), right trigger thumb release (unknown date), and left carpal tunnel release (CTR) (03/28/2014). Diagnostic testing has included x-rays of the cervical spine revealing solid osseous fusion at C6-C7, and degenerative disc disease at C5-C6 that is severe with endplate sclerosis and anterior osteophytic spurring. A cervical MRI revealed C5-C6-C7 vertebral interbody fusion, C5-C6 moderate degenerative disc disease, and C3-C4 and C4-C5 mild disc bulging. Current diagnoses include cervical spondylosis and facet arthropathy (C4-C7), right cervical dystonia, right supraspinatus teninopathy, right labral tear with prior labral cyst, bilateral carpal tunnel syndrome status post carpal tunnel releases, cervicothoracic strain, right lateral epicondylitis (noted as improved), left trigger thumb improved post-surgery, right third trigger finger, and right second finger stenosing tenosynovitis. The pain management medial branch block under fluoroscopic guidance at the right C4, C5, C6 and C7 levels was requested for the treatment of cervical pain. Treatments in place around the time the pain management medial branch block was requested included medications, activity restrictions, and home exercises. The injured worker reported pain was decreased from the previous visit. Functional deficits and activities of daily living were improved. Work status was unchanged as the injured worker remained retired. Dependency on medical care was unchanged. On 12/17/2014, Utilization Review non-certified a request for pain management medial branch block under fluoroscopic guidance at the right C4, C5, C6 and C7 which was requested on 12/11/2014. The pain management medial branch block was non-certified based on the lack of guidance or recommendation for more than two facet levels requested which included a previously fused level and the lack of sufficient long-term rehabilitation treatment prior to the blocks. The MTUS Chronic Pain and ODG guidelines were cited. This UR decision was appealed for an Independent Medical Review. The submitted application for Independent Medical Review (IMR) requested an appeal for the non-certification of pain management medial branch block under fluoroscopic guidance at the right C4, C5, C6 and C7.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain management medial branch block under fluoroscopic guidance at right C4, C5, C6 and C7: 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)- low back chapter, facet joint pain, signs and symptoms

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175, 181-183. Decision based on Non-MTUS Citation Neck and Upper Back (Acute & Chronic) Facet joint diagnostic blocks, Facet joint therapeutic steroid injections Work Loss Data Institute. Neck and upper back (acute & chronic). Encinitas (CA): Work Loss Data Institute; 2013 May 14. <http://www.guideline.gov/content.aspx?id=47589>

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses cervical facet injection. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints states that invasive techniques, such as injection of facet joints, have no proven benefit in treating acute neck and upper back symptoms. ACOEM Table 8-8 Summary of Recommendations for Evaluating and Managing

Neck and Upper Back Complaints states that facet injection of corticosteroids and diagnostic blocks are not recommended. Work Loss Data Institute guidelines for the neck and upper back (acute & chronic) states that facet joint therapeutic steroid injections are not recommended. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. Official Disability Guidelines (ODG) state that therapeutic intra-articular and medial branch blocks are not recommended. ODG guidelines state that that therapeutic intra-articular and medial branch blocks are not recommended in patients with previous fusion. Medial branch blocks procedure is generally considered a diagnostic block. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. Facet joint diagnostic block is limited to patients with cervical pain that is non-radicular. Medical records document a history of ACDF Anterior Cervical Discectomy and Fusion at C6-C7 and cervical radiculopathy. MRI magnetic resonance imaging of the cervical spine dated January 15, 2014 demonstrated C6-C7 vertebral interbody fusion. American College of Occupational and Environmental Medicine (ACOEM) Table 8-8 states that facet injection of corticosteroids and diagnostic blocks are not recommended. Work Loss Data Institute guidelines for the neck and upper back (acute & chronic) states that facet joint therapeutic steroid injections are not recommended. Official Disability Guidelines (ODG) state that therapeutic intra-articular and medial branch blocks are not recommended. ODG guidelines state that that therapeutic intra-articular and medial branch blocks are not recommended in patients with previous fusion. Per ODG criteria for the use of diagnostic blocks for facet nerve pain, facet joint diagnostic block is limited to patients with cervical pain that is non-radicular. The request for medial branch blocks are not supported by MTUS, ACOEM, ODG, Work Loss Data Institute guidelines. Therefore, the request for pain management medial branch block under fluoroscopic guidance at right C4, C5, C6 and C7 is not medically necessary.