

Case Number:	CM15-0109328		
Date Assigned:	06/15/2015	Date of Injury:	11/01/2006
Decision Date:	07/15/2015	UR Denial Date:	04/30/2015
Priority:	Standard	Application Received:	06/08/2015

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: Physical Medicine & Rehabilitation

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 45-year-old male who sustained a work related injury November 1, 2006. Past history included s/p L4-5 and L5-S1 laminectomy, discectomy 2008, ACDF (anterior cervical discectomy and fusion) C3-4, C4-5 and C5-6 June 14, 2011 with subsequent removal of hardware September 16, 2014. According to a follow-up pain management consultation, dated April 13, 2015, the injured worker presented with persistent neck pain associated with cervicogenic headaches with pain radiating down to both upper extremities. He also reports continued dizziness with intermittent loss of hearing and difficulty with his balance. The physician noted he had developed Horner's Syndrome with ptosis and myosis. He was approved for a trial spinal cord stimulator but is currently on hold pending evaluation for Wallenberg Syndrome. He is taking Flomax for urinary incontinence. Urodynamic studies were performed which demonstrated low capacity bladder with an early urge to urinate and was diagnosed with a neurogenic bladder. There is tenderness to palpation of the cervical spine musculature, trapezius, medial scapular and sub-occipital region. There are multiple trigger points and taunt bands palpated throughout. Sensory examination was decreased along the posterior lateral arm and forearm with some weakness on the left triceps. There is tenderness to palpation about the lumbar paravertebral musculature and sciatic notch region and trigger point and taunt bands throughout. Sensory examination was decreased along the posterior thigh and posterior lateral calf bilaterally, left greater than right. Straight leg raise is positive in the modified sitting position bilaterally with the left at 40 degrees and the right at 60 degrees. Diagnoses are cervical post-laminectomy syndrome; bilateral upper extremity radiculopathy, left greater than right; medication induced gastritis; reactionary depression/anxiety. At issue, is the request for authorization for cervical facet injection and lumbar facet injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical facet injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (Web), 2014, Neck & Upper Back, Facet joint therapeutic steroid injections.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines, Neck and Upper Back Chapter, under Facet joint diagnostic blocks.

Decision rationale: The patient presents on 04/13/15 with unrated neck pain which radiates into the right upper extremity. The patient's date of injury is 11/01/06. Patient is status post anterior cervical disc fusion on 06/14/11, with subsequent hardware removal on 09/16/14 and status post L4-5/L5-S1 laminectomy in 2008. The request is for CERVICAL FACET INJECTION. The RFA was not provided. Physical examination dated 04/13/15 reveals tenderness to palpation of the posterior cervical spine musculature, trapezius, medial scapular and sub-occipital region, with multiple taut bands and trigger points noted throughout. Cervical range of motion is decreased in all planes, and the provider also notes decreased sensation along the right posterior lateral arm and forearm and diffuse weakness in the left triceps muscle. Lumbar spine examination reveals tenderness to palpation in the paraspinal musculature and sciatic notch region with taut bands and trigger points noted throughout. Neurological examination reveals decreased sensation along the posterior lateral thigh and calf bilaterally, and positive straight leg raise test is noted bilaterally (at 40 degrees left, 60 degrees right). The patient is currently prescribed Norco, Anaprox, Doral, Prilosec, Neurontin, Cymbalta, MiraLAX, Norvasc, Hydrocortisone suppositories, Enablex, Fenofibrate, Prazosin, Remeron, Wellbutrin, Ativan, and Buspar. Diagnostic imaging included MRI of the cervical spine dated 02/06/15, significant findings include: "Post surgical changes are noted with fusion at C3-C4, C4-C5, and C5-C6. At C6 there is a 3mm midline disc protrusion resulting in flattening of the thecal sac with a mild degree of central canal narrowing. " A lumbar MRI dated 03/23/13 was also included, significant findings are: "L4-5 there is a 4.7mm broad based disc protrusion with facet arthrosis and moderate bilateral foraminal narrowing. " Patient's current disability level or work status is not provided. ODG-TWC, Neck and Upper Back Chapter, under Facet joint diagnostic blocks states: "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. Criteria for the use of diagnostic blocks for facet nerve pain: 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. For facet joint pain signs and symptoms, the ODG guidelines state that physical examination findings are generally described as: "1. axial pain, either with no radiation or severity 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; and 4. absence of radicular and/or neurologic findings.

" In regard to the request for a cervical facet block at unspecified levels, the patient does not meet guideline criteria. The documentation provided indicates that this patient underwent cervical fusion at C3 through C6 levels on 06/14/11. This patient presents with cervical pain, which radiates into the right upper extremity, and also exhibits neurological deficit in the affected extremity. Guidelines do not support diagnostic cervical facet blocks in patients with a history of cervical fusion, nor do they support facet joint injections in patients who present with radicular pain or neurological deficit to the upper extremities. Furthermore, the provider does not specify the desired levels to be injected - without such information the request as written cannot be substantiated. The request IS NOT medically necessary.

Lumbar facet joint injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines, Low Back Chapter, under Facet Joint Diagnostic Blocks.

Decision rationale: The patient presents on 04/13/15 with unrated neck pain, which radiates into the right upper extremity. The patient's date of injury is 11/01/06. Patient is status post anterior cervical disc fusion on 06/14/11, with subsequent hardware removal on 09/16/14 and status post L4-5/L5-S1 laminectomy in 2008. The request is for LUMBAR FACET JOINT INJECTION. The RFA was not provided. Physical examination dated 04/13/15 reveals tenderness to palpation of the posterior cervical spine musculature, trapezius, medial scapular and sub-occipital region, with multiple taut bands and trigger points noted throughout. Cervical range of motion is decreased in all planes, and the provider also notes decreased sensation along the right posterior lateral arm and forearm and diffuse weakness in the left triceps muscle. Lumbar spine examination reveals tenderness to palpation in the paraspinal musculature and sciatic notch region with taut bands and trigger points noted throughout. Neurological examination reveals decreased sensation along the posterior lateral thigh and calf bilaterally, and positive straight leg raise test is noted bilaterally (at 40 degrees left, 60 degrees right). The patient is currently prescribed Norco, Anaprox, Doral, Prilosec, Neurontin, Cymbalta, MiraLAX, Norvasc, Hydrocortisone suppositories, Enablex, Fenofibrate, Prazosin, Remeron, Wellbutrin, Ativan, and Buspar. Diagnostic imaging included MRI of the cervical spine dated 02/06/15, significant findings include: "Post surgical changes are noted with fusion at C3-C4, C4-C5, and C5-C6. At C6 there is a 3mm midline disc protrusion resulting in flattening of the thecal sac with a mild degree of central canal narrowing. " A lumbar MRI dated 03/23/13 was also included, significant findings are: "L4-5 there is a 4.7mm broad based disc protrusion with facet arthrosis and moderate bilateral foraminal narrowing. " Patient's current disability level or work status is not provided. ODG Low Back Chapter, under Facet Joint Diagnostic Blocks states: Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment - a procedure that is still considered under study. Diagnostic blocks may be 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. 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 MBBs. 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 25% to 40%) but this does not

appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. Criteria for the use of diagnostic blocks for facet mediated pain: 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). In regard to the request for a lumbar facet block at unspecified levels, the patient does not meet guideline criteria. There is no evidence in the documentation provided that this patient has undergone any lumbar facet blocks to date. Per progress notes dated 04/13/15 and 03/12/15, this patient presents with lower back pain which radiates into the bilateral lower extremities, and also exhibits symptoms of neurological deficit in the bilateral lower extremities (decreased sensation, positive SLR bilaterally). Additionally, the request does not specify the desired number of levels to be injected, therefore compliance with guidelines in regard to an appropriate number of levels to be injected cannot be established. Given this patient's lower extremity radicular pain with a neurological component, and the failure to specify levels to be injected, the request as written cannot be substantiated. The request IS NOT medically necessary.