

Case Number:	CM15-0133706		
Date Assigned:	07/21/2015	Date of Injury:	09/03/2013
Decision Date:	08/25/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	07/10/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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:

The injured worker is a 49-year-old male, who sustained an industrial injury on 09/03/2013. He has reported injury to the neck, bilateral shoulders, and low back. The diagnoses have included cervical sprain; cervical disc degeneration; lumbar sprain; lumbar disc degeneration; lumbar facet hypertrophy; left shoulder tendinosis; left shoulder impingement rotator cuff tear; and status post right shoulder arthroscopy with subacromial decompression. Treatment to date has included medications, diagnostics, chiropractic therapy, physical therapy, and surgical intervention. A progress report from the treating physician, dated 05/18/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of on and off moderate bilateral shoulder pain which increases in intensity with overhead reaching; he occasionally hears noise with movement; on and off moderate low back and upper back pain; he notes occasional numbness and tingling down his legs; on and off moderate neck pain which radiates down his arms to the hands and increases in intensity with cold weather; and he notes numbness and tingling of his arms and hands. Objective findings included decreased range of motion of the cervical spine; decreased range of motion of the lumbar spine; and there are spasms of the paracervical, trapezius, and levator scapula musculature. The treatment plan has included the request for cervical facet block injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Facet Block Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Neck & Upper Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Facet joint diagnostic blocks (injections) and Other Medical Treatment Guidelines MD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections.

Decision rationale: ACOEM Guidelines state "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". MTUS is silent specifically with regards to facet injections, but does refer to epidural steroid injections. ODG and MD Guidelines agree that: "One diagnostic facet joint injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments (e.g., NSAIDs, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended . . . If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported." ODG details additional guidelines: 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 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. The medical documentation provided indicates symptoms of radiculopathy, guidelines recommend against facet block injections with radicular symptoms. Additionally, the treating physician has not provided documentation of failure of conservative therapy as outlined above. As such, the request for Cervical Facet Block Injection is not medically necessary.