

<b>Case Number:</b>	CM15-0142518		
<b>Date Assigned:</b>	08/06/2015	<b>Date of Injury:</b>	09/12/2014
<b>Decision Date:</b>	09/29/2015	<b>UR Denial Date:</b>	06/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2015

### 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 47 year old male who sustained an industrial injury on 9-12-2014. He was pulling a refrigerator when a strap broke and he fell backwards and rolled to the side and got up. He has reported neck pain, upper back pain, left leg pain, and numbness, tingling, and weakness in the legs and feet and has been diagnosed with cervical sprain strain, cervical facet syndrome, lumbar sprain strain, and lumbar facet syndrome. Treatment has included medications, acupuncture, and chiropractic care. The pain in the arms was worse as compared to the neck. He had persistent pain in the lumbar spine with radiation to the left thigh. He had numbness and tingling in the cervical spine and the back of the neck. He also had numbness, tingling, and weakness in the legs and feet. He also noted headaches. He reports experiencing night pain, stiffness, and swelling in the lumbar spine. The treatment plan included chiropractic care and facet block. The treatment request included left C5-C6 and C6-C7 facet block.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left C5-C6 and C6-C7 Facet Block:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS Decision based on Non-MTUS Citation Official Disability Guidelines, Facet Joint Injections.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, under Facet joint diagnostic blocks.

**Decision rationale:** The patient presents with pain in the neck, mid-back, low back, left leg and shoulder (side unspecified). The request is for LEFT C5-C6 AND C6-C7 FACET BLOCK. Physical examination to the cervical spine on 06/09/15 revealed multiple paracervical tender points and trigger points. Range of motion was reduced with pain in all planes. Examination to the lumbar spine revealed multiple tender points and trigger points. Range of motion was restricted in all planes. Patient's treatments have included lumbar ESI's, acupuncture and chiropractic therapy with benefits. Per 04/28/15 progress report, patient's diagnosis include lumbosacral radiculitis/radiculopathy, cervical radiculitis/radiculopathy, and myofascial pain. Patient's medications, per 03/17/15 progress report include anti-inflammatories and Atenolol. Patient's work status is modified duties. MTUS/ACOEM Neck Complaints, Chapter 8, page 174- 175, under Initial Care states: for Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints, or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injections may help patients presenting in the transitional phase between acute and chronic pain. 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: 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. The treater has not addressed this request and no RFA was provided either. In this case, there are no records indicating that the patient had prior facet joint injections at the levels requested. Guidelines do not support such procedures in patients who present with radicular pain. Although the treater has not documented any subjective radicular cervical pain, patient's diagnosis includes cervical radiculitis/radiculopathy. While this patient presents with significant pain poorly controlled by other measures, the presence of radiculopathy in this patient precludes lumbar facet injections, diagnostic or otherwise. Therefore, the request IS NOT medically necessary.

**Left L4-L5 and L5-S1 Facet Block:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS Citation Official Disability Guidelines, Facet Joint Injections.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, under Facet Joint Diagnostic Blocks.

**Decision rationale:** The patient presents with pain in the neck, mid-back, low back, left leg and shoulder (side unspecified). The request is for LEFT L4-L5 AND L5-S1 FACET BLOCK. Physical examination to the cervical spine on 06/09/15 revealed multiple paracervical tender points and trigger points. Range of motion was reduced with pain in all planes. Examination to the lumbar spine revealed multiple tender points and trigger points. Range of motion was restricted in all planes. Patient's treatments have included lumbar EST's, acupuncture and chiropractic therapy with benefits. Per 04/28/15 progress report, patient's diagnosis include lumbosacral radiculitis/radiculopathy, cervical radiculitis/radiculopathy, and myofascial pain. Patient's medications, per 03/17/15 progress report include anti-inflammatories and Atenolol. Patient's work status is modified duties. 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: 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. ACOEM Practice Guidelines, Chapter 12, low back complaints, under "Physical Methods," pages 300 states Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. The treater has not addressed this request and no RFA was provided either. In this case, there are no records indicating that the patient had prior facet joint injections at the levels requested. Guidelines do not support such procedures in patients who present with radicular pain. Although the treater has not documented any subjective radicular lumbar pain, patient's diagnosis includes lumbosacral radiculitis/radiculopathy. While this patient presents with significant chronic pain poorly controlled by other measures, the presence of radiculopathy in this patient precludes lumbar facet injections, diagnostic or otherwise. Therefore, the request IS NOT medically necessary.