

Case Number:	CM15-0186864		
Date Assigned:	09/28/2015	Date of Injury:	08/25/2014
Decision Date:	11/25/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/22/2015

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, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

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 is a 50 year old male who sustained a work-related injury on 8-25-14. Medical record documentation on 9-8-15 revealed the injured worker was being treated for cervicgia and headache. He rated his pain a 6-7 on a 10-point scale. His medication regimen included Norco and IBP. Objective findings included decreased cervical spine range of motion in all directions 5-10 degrees with pain. He had a positive Spurling test with radiculopathy along the left C5, C6, and C7 dermatomes and his sensation was decreased along the left C7 dermatome. An EMG-NCV of the bilateral upper extremities on 4-9-15 revealed evidence of left chronic C6 radiculopathy. An MRI of the cervical spine on 8-18-15 revealed a 1-2 mm disc osteophyte complex encroaching upon the ventral epidural space contacting but not compressing the ventral spinal cord along C5-6. There was a disc height reduction with posterior broad-based bulging 2mm beyond the endplate margin at C6-7. He had no cord compression, no central canal stenosis of C5-6. He had patent bilateral foraminal in C5-6 and mild bilateral foraminal narrowing of C6-7. A request for cervical epidural steroid facet injection at C5-C7 was received on 9-9-15. On 9- 14-15, the Utilization Review physician determined cervical epidural steroid facet injection at C5-C7 was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Epidural Steroid Facet Injection at C5-C7: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Facet joint therapeutic steroid injections.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, Surgical Considerations.

Decision rationale: CA MTUS/ACOEM Chapter 8, Neck and Upper Back Complaints, Table 8-8, page 181, does not recommend facet injection of corticosteroids or diagnostic blocks in the cervical spine. As the guidelines do not recommend facet blocks, the determination is for non-certification. ODG-TWC, neck section notes that facet joint diagnostic blocks are 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. 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 (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy. 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 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. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. 12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. As the referenced guidelines do not recommend facet blocks, the determination is for non-certification, therefore is not medically necessary.