

Case Number:	CM15-0189738		
Date Assigned:	10/01/2015	Date of Injury:	12/24/2013
Decision Date:	11/16/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/25/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 44 year old female, who sustained an industrial injury on 12-11-2013. She has reported injury to the neck. The diagnoses have included neck pain; multilevel cervical spondylosis with C6-7 congenital fusion; cervical strain; and status post right shoulder biceps tendonitis and subscapularis repair. Treatment to date has included medications, diagnostics, activity modification, acupuncture, physical therapy, bilateral C3-4 facet blocks, and surgical intervention. Medications have included Naprosyn, Norco, Tramadol, and Cyclobenzaprine. A progress report from the treating provider, dated 09-03-2015, documented an evaluation with the injured worker. The injured worker reported neck pain, predominantly on the right; and she is currently working. It is noted in the documentation that acupuncture and physical therapy have been helpful with motion and pain. Objective findings included decreased cervical spine ranges of motion; decreased grip strength on the right; neck pain increased with cervical extension with tenderness of the right paraspinal muscles; and she has abnormalities at C3-4, C4-5, and C5-6 above a congenital fusion at C6-7. The treatment plan has included the request for right C4-5, C5-6 facet injections; and cervical spine x-rays flexion-extension views. The original utilization review, dated 09-14-2015, non-certified the request for right C4-5, C5-6 facet injections; and cervical spine x-rays flexion-extension views.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right C4-5, C5-6 facet injections: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines- Low Back Lumbar & Thoracic.

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

Decision rationale: Per the ODG Guidelines with regard to facet joint diagnostic blocks: 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). 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 MBB. 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 27% to 63%) 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 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. The medical records submitted for review do not document a failure of conservative treatment. It was noted that the injured worker improved with acupuncture and physical therapy. As the criteria are not met, the request is not medically necessary.

Cervical spine X-rays flexion -extension views: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back, Flexion/extension Imaging Studies.

Decision rationale: Per the ODG guidelines regarding flexion/extension imaging studies: Not recommended as a primary criteria for range of motion. An inclinometer is the preferred device for obtaining accurate, reproducible measurements. See Range of motion (ROM); Flexibility. For spinal instability, may be a criteria prior to fusion, for example in evaluating symptomatic spondylolisthesis when there is consideration for surgery. See Fusion (spinal). Per the medical records submitted for review, x-rays of the cervical spine were taken 3/4/15 which revealed a C6-C7 congenital fusion. Flexion and extension and laterals were taken. There was no evidence of instability. It was noted that there was a vestigial disc noted at the region of the congenital fusion at C6-C7. Previous MRI of the cervical spine dated 2/5/15 did not indicate the presence of a spondylolisthesis. There is no indication of instability or consideration of surgery, the request is not medically necessary.