

Case Number:	CM15-0191406		
Date Assigned:	10/05/2015	Date of Injury:	01/24/2000
Decision Date:	11/10/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	09/29/2015

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: Montana, Oregon, Idaho
 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:

The 37 year old female injured worker suffered an industrial injury on 1-24-2000. The diagnoses included cervical fusion, cervicgia, cervical disc disease and cervical neuropathy. On 7-21-2015, the treating provider reported. The pain was rated 6 out of 10 with severe diffuse pain with numbness in the left upper extremity. On exam, the cervical muscles had spasms with 50% reduction in range of motion. The medications in use were Tramadol, Soma and Maxalt. The provider noted the residual numbness in the left upper extremity was diffuse which was not radiculopathy, but consistent with brachial plexopathy. Cervical distraction and compression were positive for diffuse facet tenderness. Request for Authorization date was 8-31-2015. The Utilization Review on 9-10-2015 determined non-certification for Bilateral C5-6 and C6-7 facet medial branch blocks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral C5-6 and C6-7 facet medial branch blocks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back, Facet Injection, ACOEM 2013, Cervical and Thoracic Spine Disorders, Clinical Measures, Injection Therapy.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck.

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. 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 MTUS/ACOEM guidelines do not recommend facet blocks. In addition, the injured worker has already undergone cervical facet joint injections, which produced only 40-50% relief, which according to the ODG guidelines, is not considered a positive response. Therefore, the determination is for non-certification. The request is not medically necessary.