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| Case Number: | CM15-0200046 | | |
| Date Assigned: | 10/15/2015 | Date of Injury: | 05/09/2002 |
| Decision Date: | 12/02/2015 | UR Denial Date: | 09/29/2015 |
| Priority: | Standard | Application Received: | 10/12/2015 |

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 61 year old female, who sustained an industrial injury on 5-9-2002. Medical records indicate the worker is undergoing treatment for left occipital headache, cervical and trapezial myofascial pain, cervical radiculopathy and cervical facet syndrome. A recent progress report dated 9-10-2015, reported the injured worker complained of constant cervical aching. Physical examination revealed cervical paraspinal tenderness to palpation and the greatest pain with extension. Cervical x rays showed prior anterior cervical fusion with no hardware loosening and cervical 4-5 osteophyte formation. Treatment to date has included cervical epidural steroid injection on 7-6-2015 with significant pain relief noted, physical therapy and medication management. On 9-10-2015, the Request for Authorization requested cervical medial branch blocks at bilateral cervical 4 and 5. On 9-29-2015, the Utilization Review noncertified the request for cervical medial branch blocks at bilateral cervical 4 and 5.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical facet MBB (medial branch block) at bilateral C4: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Low Back - Lumbar & Thoracic (Acute & Chronic): Facet joint diagnostic blocks (injections).

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 documentation submitted for review indicates that the injured worker suffers from upper extremity radiculopathy. Treatment has included cervical epidural steroid injection to left C5-C6 on 7/6/15. As radicular pain is an exclusionary criteria, the request is not medically necessary.

Cervical facet MBB (medial branch block) at bilateral C5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Low Back - Lumbar & Thoracic (Acute & Chronic): Facet joint diagnostic blocks (injections).

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 documentation submitted for review indicates that the injured worker suffers from upper extremity radiculopathy. Treatment has included cervical epidural steroid injection to left C5-C6 on 7/6/15. As radicular pain is an exclusionary criteria, the request is not medically necessary.