

<b>Case Number:</b>	CM15-0027055		
<b>Date Assigned:</b>	02/19/2015	<b>Date of Injury:</b>	07/01/2014
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	02/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2015

### 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: Arizona, California  
 Certification(s)/Specialty: Family Practice

### 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 32 year old male with an industrial injury dated July 1, 2014. The injured worker diagnoses include cervical spondylosis, cervical facet arthropathy, and cervical sprain/strain. He has been treated with diagnostic studies, radiographic imaging, prescribed medications, and periodic follow up visits. ON 11/26/14 the claimant's MRI showed disc protrusions and disc herniation from C4-C6. In a progress note dated 12/19/2014, his treating physician noted neck pain with radiation to bilateral upper extremities. Physical exam revealed severe tenderness to palpitation of the mid to lower cervical spine. There was noted neck pain upon extension after twenty degrees. Treating physician noted that the cervical x-ray revealed no instability and MRI of the cervical spine revealed C5-C6 and C6-C7 2mm broad based disc bulge. There was mild canal stenosis noted with facet arthropathy. The treating physician is requesting 1 cervical bilateral facet injections to C5-C6 and C6-C7 and 1 soft collar. UR determination on February 6, 2015 denied the request for 1 cervical bilateral facet injections to C5-C6 and C6-C7 and 1 soft collar citing MTUS, ACOEM and Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Cervical bilateral facet injections to C5-C6 and C6-C7: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-5. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Neck chapter and facet blocks

**Decision rationale:** According to the ODG guidelines, the criteria for diagnostic facet blocks are as follows: 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. 1. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 2. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 3. When performing therapeutic blocks, no more than 2 levels may be blocked at any one time. 4. If prolonged evidence of effectiveness is obtained after at least one therapeutic block, there should be consideration of performing a radiofrequency neurotomy. 5. There should be evidence of a formal plan of rehabilitation in addition to facet joint injection therapy. No more than one therapeutic intra-articular block is recommended. 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. In this case, there was no plan for a formal rehab plan in conjunction with the injection request. In addition, the injections are considered appropriate prior to a neurotomy; however, there was no mention of a plan for a neurotomy. As a result, the request for the injections is not medically necessary.

**1 Soft collar:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS.  
Decision based on Non-MTUS Citation ODG and neck pain-collars

**Decision rationale:** According to the guidelines, collars are not recommended for sprains. They may be used post-operatively or when a fracture exists. The claimant did not have an indication for a collar and is therefore not medically necessary.