

Case Number:	CM15-0212817		
Date Assigned:	11/02/2015	Date of Injury:	05/13/1993
Decision Date:	12/14/2015	UR Denial Date:	10/14/2015
Priority:	Standard	Application Received:	10/29/2015

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: 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:

The injured worker is a 48 year old male, who sustained an industrial injury on 5-13-1993. Diagnoses include chronic pain syndrome, displacement of lumbar disc without myelopathy, neck sprain, and irritable bowel syndrome, status post at least 5 cervical surgeries, and status post lumbar surgery. Treatments to date include activity modification, medication therapy, cervical epidural injection and facet blocks, and sacroiliac joint block, and insertion of a spinal cord stimulator. On 8-27-15, he complained of ongoing pain in low back, upper back, neck, and bilateral upper and lower extremities. Pain was rated 7 out of 10 VAS. The physical examination documented sacroiliac tenderness, with multiple positive tests including: FABER test, lateral leg lift, shear test, and thigh thrust on the left side. The lumbar spine was tender with painful range of motion. The plan of care included bilateral sacroiliac joint injections. On re-evaluation on 9-4-15, the focus was on the complaints of neck pain and radiation to bilateral upper extremities. The physical examination documented cervical tenderness, decreased range of motion, and decreased sensation to right forearm and hand. The provider documented "it is likely that he is having pain from the facets at C4-5 and C7-T1" and suggested Medical branch blocks as diagnostic test to cover those joints. The appeal requested authorization for one sacroiliac joint block and one medial branch block. The Utilization Review dated 10-14-15, denied the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Sacroiliac joint block: 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), Hip and Pelvis (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis, Sacroiliac joint blocks.

Decision rationale: CA MTUS/ACOEM is silent on the issue of sacroiliac joint injection. According to the ODG Hip and Pelvis, Sacroiliac joint blocks it is recommended as an option if 4-6 weeks of aggressive conservative therapy has been failed. In addition there must be at least 3 positive exam findings such as a pelvic compression test, Patrick's test and pelvic rock test. In this case, there is no evidence of aggressive conservative therapy being performed prior to the request for the sacroiliac joint injection. Additionally on the exam from 9/4/15, it appears as if the focus was on the complaints of neck pain and radiation to bilateral upper extremities. The physical examination documented cervical tenderness, decreased range of motion, and decreased sensation to right forearm and hand. Therefore, the guideline criteria have not been met and the request is not medically necessary.

Medial branch block: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Summary, Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck section / Facet joint diagnostic blocks (injections).

Decision rationale: CA MTUS/ACOEM Chapter 8, Neck and Upper Back Complaints, initial care & summary of recommendations, do 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 / Facet joint diagnostic blocks (injections), 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. On 9/4/15 this patient complained of neck pain that radiated to both upper extremities. ODG guidelines recommend cervical MBB in "patients with cervical pain that is non-radicular and at no more than two levels bilaterally." As the referenced guidelines have not been met, the request is not medically necessary.