

Case Number:	CM15-0213460		
Date Assigned:	11/03/2015	Date of Injury:	10/23/2010
Decision Date:	12/18/2015	UR Denial Date:	10/01/2015
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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 62-year-old female, who sustained an industrial-work injury on 10-23-10. A review of the medical records indicates that the injured worker is undergoing treatment for cervical spondylosis, chronic neck pain and psychogenic pain. Medical records dated 9-23-15 indicate that the injured worker complains of chronic persistent neck pain rated 7 out of 10 on the pain scale with radiation to the bilateral upper extremities. The pain is worse with forward flexion and rotational movements of the neck. The physical exam of the neck reveals decreased range of motion in flexion at 10 degrees and extension at 15 degrees, Spurling's maneuver elicits radicular symptoms, the muscle tone of the trapezius is increased, there is palpable tenderness and there is reproducible pain with extension and rotation of the cervical spine. The physician indicates that Magnetic Resonance Imaging (MRI) of the cervical spine dated 1-7-11 reveals cervical spondylosis with multi-level disc desiccation with bulges and small protrusion, moderate to severe neural foraminal stenosis with right annular fissure and protrusion causing stenosis. Treatment to date has included pain medication Norco and Flexeril, status post lumbar fusion in 2011 with some benefit, physical therapy, massage therapy, Transcutaneous electrical nerve stimulation (TENS), cervical facet injections, cervical radiofrequency ablation multiple times the latest on 5-17-13, providing 70 percent pain relief over a year and ability to stand longer, reach over her head and increased motion in the neck and shoulder region. The requested service included bilateral permanent cervical facet injection at C4-5 and C5-6 with arthrogram, fluoroscopic guidance and IV sedation. The original Utilization review dated 10-1-15 non-certified the request for bilateral permanent cervical facet injection at C4-5 and C5-6 with arthrogram, fluoroscopic guidance and IV sedation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral permanent cervical facet injection at C4-5 and C5-6 with arthrogram, fluoroscopic guidance and IV sedation: Overturned

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Facet joint diagnostic blocks (injections) and Other Medical Treatment Guidelines MD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections.

Decision rationale: ACOEM Guidelines state, "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain." MTUS is silent specifically about facet injections, but does refer to epidural steroid injections. ODG and MD Guidelines agree that: "One diagnostic facet joint injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments (e.g., NSAIDs, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended. If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported." ODG details additional guidelines: 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 last at least 2 hours for Lidocaine. 2. Limited to patients with low-back 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 facet 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. 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 (including other agents such as midazolam) 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. (Resnick, 2005). 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. The treating

physician does provide objective and subjective findings to meet the above criteria. Treatment notes did detail other conservative treatment failures. As such, the request for bilateral permanent cervical facet injection at C4-5 and C5-6 with arthrogram, fluoroscopic guidance and IV sedation is medically necessary.