

Case Number:	CM15-0217207		
Date Assigned:	11/06/2015	Date of Injury:	10/27/2014
Decision Date:	12/21/2015	UR Denial Date:	10/21/2015
Priority:	Standard	Application Received:	11/04/2015

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:

This is a 54 year old male who sustained an industrial injury on 10-27-2014. A review of the medical records indicates that the injured worker is undergoing treatment for spondylosis without myelopathy or radiculopathy of cervical region, cervical radiculopathy, occipital neuralgia and myalgia. According to the progress report dated 10-13-2015, the injured worker complained of neck pain radiating down the radial aspect of the right arm, including the radial aspect of the right forearm and thumb, radiating to the right shoulder and between shoulder blades. He also complained of upper neck pain radiating around the skull and triggering frequent headaches. He reported 30% pain relief from cervical epidural steroid injection. Objective findings (10-13- 2015) revealed restricted cervical range of motion. There was tenderness and trigger points of the cervical paravertebral muscles. Spinous process tenderness was noted on C5, C6 and C7. Cervical facet loading was positive on the right side. Treatment has included physical therapy and medications. Current medications (10-13-2015) included Ibuprofen and Naprosyn. The injured worker underwent bilateral occipital nerve block and trigger point injections of the bilateral cervical paravertebrals on 10-13-2015. Immediately after the procedure, the injured worker reported moderate pain relief. The treatment plan was for diagnostic cervical medial branch blocks at right C4, C5 and C6. The original Utilization Review (UR) (10-21-2015) denied a request for diagnostic cervical medial branch blocks at right C4, C5 and C6.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic cervical medial branch blocks right C4 per 10/13/2015 order: 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), Neck and upper back (Acute & Chronic) - Facet joint diagnostic blocks.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, Summary. 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, does 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. In this case the patient does not meet CA MTUS or ODG criteria for the proposed injection. ODG states that MBB should be "limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally." The notes from 10/13/15 show that this patient has radicular complaints and is being treated for cervical radiculopathy. Additionally no more than 2 joint levels are injected in one session (see above for medial branch block levels). As the referenced guidelines do not recommend facet blocks, the blocks are not medically necessary and determination is for non-certification.

Diagnostic cervical medial branch blocks right C5 per 10/13/2015 order: 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), Neck and upper back (Acute & Chronic) - Facet joint diagnostic blocks.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, Summary. 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, does 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. In this case the patient does not meet CA MTUS or ODG criteria for the proposed injection. ODG states that MBB should be "limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally." The notes from 10/13/15 show that this patient has radicular complaints and is being treated for cervical radiculopathy. Additionally no more than 2 joint levels are injected in one session (see above for medial branch block levels). As the referenced guidelines do not recommend facet blocks, the blocks are not medically necessary and determination is for non-certification.

Diagnostic cervical medial branch blocks right C6 per 10/13/2015 order: 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), Neck and upper back (Acute & Chronic) - Facet joint diagnostic blocks.

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, does 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. In this case the patient does not meet CA MTUS or ODG criteria for the proposed injection. ODG states that MBB should be "limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally." The notes from 10/13/15 show that this patient has radicular complaints and is being treated for cervical radiculopathy. Additionally no more than 2 joint levels are injected in one session (see above for medial branch block levels). As the referenced guidelines do not recommend facet blocks, the blocks are not medically necessary and determination is for non-certification.