

<b>Case Number:</b>	CM15-0221511		
<b>Date Assigned:</b>	11/17/2015	<b>Date of Injury:</b>	02/23/2013
<b>Decision Date:</b>	12/30/2015	<b>UR Denial Date:</b>	11/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/11/2015

### 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 37 year old female, who sustained an industrial injury on 02-23-2013. The injured worker is currently permanent and stationary. Medical records indicated that the injured worker is undergoing treatment for cervical disc disease, cervical radiculopathy, status post lumbar laminectomy, lumbar disc disease, lumbar radiculopathy, and lumbar facet syndrome. Treatment and diagnostics to date has included physical therapy, chiropractic treatment, and medications. Recent medications have included Tramadol, Fexmid, Motrin, and Lidoderm patches. Subjective data (10-02-2015) included cervical spine (rated 5 out of 10 on the pain scale) and lumbar spine (7 out of 10) pain. Objective findings (10-02-2015) included positive Spurling sign, facet tenderness to palpation at C4-C7 and L4-S1 levels, "moderate" cervical paraspinal muscle tenderness and spasm to bilateral trapezii, "diffuse" lumbar paraspinal muscle tenderness, positive bilateral Farfan test, and decreased sensation in the L5 and S1 dermatomes bilaterally. The request for authorization dated 10-28-2015 requested bilateral C4-C5 and C5-C6 trans-facet epidural steroid injection. The Utilization Review with a decision date of 11-04-2015 non-certified the request for bilateral C4-C5 and C5-C6 trans-facet epidural steroid injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral C4-C5 and C5-C6 Trans-facet Epidural Steroid Injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**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. As the referenced guidelines do not recommend facet blocks, the request is not medically necessary.