

Case Number:	CM15-0032371		
Date Assigned:	02/25/2015	Date of Injury:	03/03/2014
Decision Date:	04/07/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/20/2015

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 52 year old male, who sustained an industrial injury on 3/3/2014. The current diagnoses are sprain/strain of the neck and cervical spinal stenosis. Currently, the injured worker complains of persistent, severe neck pain. Per notes, the pain in his neck is nearly constant and made worse with extension and rotation of the cervical spine. Current medications are Hydrocodone, Cialis, Flexeril, Gabapentin, and Naproxen. The physical examination of the cervical spine reveals pain and tenderness over the C5-C6 and C7 facets bilaterally. There is decreased sensation to light touch and pinprick along the right C6 dermatome. Treatment to date has included medications. MRI of the cervical spine (11/5/2014) shows disc spur complex at multiple levels, most prominent at C3-C4. There is central disc protrusion that deforms the ventral surface of the cord; disc is slightly migrated superiorly in the subligamentous space. This is causing mild spinal stenosis and deformity of the ventral surface of the cord. His spinal canal stenosis extends from C3-C7. The treating physician is requesting diagnostic cervical medial branch block at bilateral C4-C5 and C5-C6 with fluoroscopic guidance and IV sedation, which is now under review. On 1/27/2015, Utilization Review had non-certified a request for diagnostic cervical medial branch block at bilateral C4-C5 and C5-C6 with fluoroscopic guidance and IV sedation. The California MTUS ACOEM and Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic cervical medial branch block at bilateral C4-C5 and C5-C6 with fluoroscopic guidance and IV sedation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back-Facet joint therapeutic steroid injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

Decision rationale: According MTUS guidelines, “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.” According to ODG guidelines regarding facets injections, “Under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (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). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti , 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial.” Furthermore and according to ODG guidelines, “Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: 1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. 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). 4. No more than 2 joint levels may be blocked at any one time. 5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. In this case, there is no documentation of facet mediated pain; there is no clear evidence or documentation that cervical facets are main pain generator. There is no evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. There is no clear evidence that the diagnosis of radiculopathy was excluded. Therefore, the request for Diagnostic cervical medial branch block at bilateral C4-C5 and C5-C6 with fluoroscopic guidance and IV sedation is not medically necessary.