

Case Number:	CM15-0044676		
Date Assigned:	03/17/2015	Date of Injury:	03/07/2000
Decision Date:	04/17/2015	UR Denial Date:	03/03/2015
Priority:	Standard	Application Received:	03/10/2015

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
 Certification(s)/Specialty: Family Practice

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 57-year-old male who sustained an industrial slip and fall injury with fracture to the right scapula on March 7, 2000. The injured worker was diagnosed with cervical radiculopathy, cervical facet arthropathy, cervical myofascial strain, carpal tunnel syndrome and occipital neuralgia. The injured worker is status post extra-articular right scapular fracture and coracoacromial ligament resection in 2001, status post right and left carpal tunnel releases in 2005, radiofrequency facet joint nerve blocks bilaterally to C4, C5 and C6 times 2 and trigger point injections between C4-C7. Recent cervical spine X-rays were performed on July 9, 2014. According to the primary treating physician's progress report on December 12, 2014, the injured worker continues to experience aching and shocking with radiation into the occipital region, left side greater than right side. He reports intermittent numbness, pins and needles to the bilateral hands strongest in the 3rd, 4th and 5th digits. The injured worker also notes that he has increased pain in the left shoulder due to overcompensation since his right scapular repair. Current medications consist of Trazadone, Neurontin, Norco, Anaprox and topical analgesics. The treating physician is requesting bilateral medial branch blocks at C4-C5, C5-C6 and C6-C7.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral medial branch block at C4-C5, C5-C6, C6-C7: 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 section - Facet Joint Diagnostic Blocks.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Neck Section: Facet Joint Therapeutic Steroid Injections.

Decision rationale: The Official Disability Guidelines comment on the use of medial branch blocks for the treatment of neck pain. The Official Disability Guidelines state the following on this treatment modality: Medial branch blocks: This procedure is generally considered a diagnostic block. There is one randomized controlled trial (RCT) comparing the effect of medial branch blocks with bupivacaine alone to blocks with the same local anesthetic plus steroid (60 patients in each group). No placebo arm was provided. Patients with radicular symptoms were excluded. Patients with uncontrolled major depression or psychiatric disorders and those with heavy opioid use were also excluded. Pain reduction per each individual block in both groups ranged from 14 to 16 weeks. It was opined that there was no role for steroid in the blocks, and the mechanism for the effect of local anesthetic only could only be speculated on. It was also noted that blocks were required 3 to 4 times a year for continued pain relief. Complications: Low rates of infection, dural puncture, spinal cord trauma, spinal anesthesia, chemical meningitis, neural trauma, pneumothorax, radiation exposure, facet capsule rupture, hematoma formation and side effects of steroids. Fluoroscopy is recommended to avoid arterial, intrathecal, or spinal injection. While not recommended, criteria for use of therapeutic intra-articular and medial branch blocks, if used anyway: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 2. 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). 3. When performing therapeutic blocks, no more than 2 levels may be blocked at any one time. 4. If prolonged evidence of effectiveness is obtained after at least one therapeutic block, there should be consideration of performing a radiofrequency neurotomy. 5. There should be evidence of a formal plan of rehabilitation in addition to facet joint injection therapy. 6. No more than one therapeutic intra-articular block is recommended. In this case, the request is for a therapeutic block at 3 levels. Per the above-cited guidelines, no more than 2 levels may be blocked at any one time. Further, there is insufficient evidence that the patient has facet joint symptoms as the cause of chronic pain. Additional documentation in support of this diagnosis would be needed to justify the use of a medial branch block. There was no evidence of a formal plan of rehabilitation in addition to facet joint injection therapy. For these reasons, bilateral medial branch block at C5-C5, C5-C6 and C6-C7 is not considered as medically necessary.