

<b>Case Number:</b>	CM15-0047260		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	10/26/1995
<b>Decision Date:</b>	04/24/2015	<b>UR Denial Date:</b>	03/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2015

### 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 63 year old female, who sustained an industrial injury on October 26, 1995. The injured worker was diagnosed as having status post positive fluoroscopically-guided right C2-3 and right C3-4 facet joint medial branch block, cervicogenic headaches, bilateral upper cervical facet joint pain at C2-C3, C3-C4, cervical facet joint arthropathy, chronic neck pain, bilateral lumbar facet joint pain, lumbar facet joint arthropathy, chronic low back pain and cubital tunnel syndrome. Treatment to date has included positive fluoroscopically-guided right C2-3 and right C3-4 facet joint medial branch block. Currently, the injured worker complains of bilateral neck pain with radiation to bilateral shoulders with cervicogenic headaches. In a progress note dated February 27, 2015, the treating provider reports tenderness upon palpation of cervical paraspinal muscles overlying the bilateral C2-C3, C3-C4 and C4-C5 facet joints, tenderness upon palpation of the lumbar paraspinal muscles overlying the bilateral L4-L5 and L5-S1 facet joints and decreased range of motion of the cervical spine. The recommendations are a fluoroscopically guided right C2-C3 and C3-C4 facet joint radio frequency nerve ablation and fluoroscopically guided diagnostic left C2-C3 and left C3-C4 facet joint medial branch block.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Bilateral C4-C5 Fluoroscopic Guided Neurotomy/Rhizotomy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Harris J, Occupational Medicine Practice Guidelines, 2nd Edition (2004), pp. 174 and Official Disability Guidelines - TWC, Neck and Upper Back (Acute & Chronic), Cervicogenic headache, facet joint neurotomy, Cervical facet radiofrequency neurotomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Facet joint intra-articular injections (therapeutic blocks) ([http://worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm#Facetjointinjections](http://worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#Facetjointinjections)).

**Decision rationale:** According to 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. According to MTUS guidelines, “there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks.” The ODG guidelines did not support facet injection for

cervical pain in this clinical context. There is no documentation of facet mediated pain or that facets are the main pain generator. There is no documentation of failure of conservative therapies in this patient. No more than 2 level facet injections at one session are authorized by the guidelines. In addition, there is no documentation on a plan of rehabilitation put in place in addition to facet joint therapy. Therefore, the request for Bilateral C4-C5 Fluoroscopic Guided Neurotomy/Rhizotomy is not medically necessary.

### **Bilateral C5-C6 Fluoroscopic Guided Neurotomy/Rhizotomy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Harris J, Occupational Medicine Practice Guidelines, 2nd Edition (2004), pp. 174 and Official Disability Guidelines - TWC, Neck and Upper Back (Acute & Chronic), Cervicogenic headache, facet joint neurotomy, Cervical facet radiofrequency neurotomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 181. Decision based on Non-MTUS Citation Facet joint intra-articular injections (therapeutic blocks) ([http://worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm#Facetjointinjections](http://worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#Facetjointinjections)).

**Decision rationale:** According to 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 facet 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 concert 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. According to MTUS guidelines, “there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region.

Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks.” The ODG guidelines did not support facet injection for cervical pain in this clinical context. There is no documentation of facet mediated pain or that facets are the main pain generator. There is no documentation of failure of conservative therapies in this patient. No more than 2 level facet injections at one session are authorized by the guidelines. In addition, there is no documentation on a plan of rehabilitation put in place in addition to facet joint therapy. Therefore, the request for Bilateral C6-C6 Fluoroscopic Guided Neurotomy/Rhizotomy is not medically necessary.

### **Bilateral C6-C7 Fluoroscopic Guided Neurotomy/Rhizotomy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Harris J, Occupational Medicine Practice Guidelines, 2nd Edition (2004), pp. 174 and Official Disability Guidelines - TWC, Neck and Upper Back (Acute & Chronic), Cervicogenic headache, facet joint neurotomy, Cervical facet radiofrequency neurotomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Facet joint intra-articular injections (therapeutic blocks) ([http://worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm#Facetjointinjections](http://worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#Facetjointinjections)).

**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. According to MTUS guidelines, “there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks.” The ODG guidelines did not support facet injection for cervical pain in this clinical context. There is no documentation of facet mediated pain or that facets are the main pain generator. There is no documentation of failure of conservative therapies in this patient. No more than 2 level facet injections at one session are authorized by the guidelines. In addition, there is no documentation on a plan of rehabilitation put in place in addition to facet joint therapy. Therefore, the request for Bilateral C6-C7 Fluoroscopic Guided Neurotomy/Rhizotomy is not medically necessary.



