

<b>Case Number:</b>	CM15-0081286		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	03/10/2005
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	04/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2015

### 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, Alabama, 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 56-year-old male, with a reported date of injury of 03/10/2005. The diagnoses include cervical facet arthropathy, status post cervical surgery, right upper extremity pain, possible cervical radiculopathy, and status post anterior cervical discectomy and fusion at C4-5, C5-6, and C6-7. Treatments to date have included oral medications, a computerized tomography (CT) scan of the cervical spine, acupuncture, topical pain medication, right cervical facet medial branch block at C7-T1 facet on 02/19/2015, which lowered his pain level from 6 out of 10 to 3 out of 10 for several hours, physical therapy, a transcutaneous electrical nerve stimulation (TENS) unit, x-rays of the cervical spine, and chiropractic treatment. The progress report dated 03/26/2015 indicates that the injured worker had neck pain, rated 5-6 out of 10. He noted persistent tightness in his neck. The physical examination showed limited cervical range of motion in all planes, pain with facet loading of the cervical spine, tenderness to palpation in the upper cervical facet regions, tenderness to palpation at C7-T1 facets, positive facet loading at C7-T1 bilaterally, greater on the right, and intact sensation in the bilateral upper extremities. The treating physician requested a second confirmatory medial branch block injection at the right C7-T1. It was noted that the treating physician was unable to determine if the injured worker was a candidate for rhizotomy of the nerves.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**2nd Confirmatory Medial Branch Block Injection, Cervical Spine, Right C7-T1 (thoracic):**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-194. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back chapter - Facet joint diagnostic blocks.

**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%, and 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. There is no documentation of significant functional improvement from the previous cervical facet medial branch block at C7-T1 facet, performed on February 19, 2015. There is no documentation of failure of conservative therapies in this patient. In addition, the possibility of cervical radiculopathy is not excluded in this case. There is no rationale behind requesting a second diagnostic medial branch block. Therefore, the request for 2nd Confirmatory Medial Branch Block Injection, Cervical Spine, Right C7-T1 (thoracic) is not medically necessary.