

Case Number:	CM15-0099360		
Date Assigned:	06/02/2015	Date of Injury:	03/07/2000
Decision Date:	07/07/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	05/26/2015

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 57 year old male, who sustained an industrial/work injury on 3/7/00. He reported initial complaints of neck and scapular pain. The injured worker was diagnosed as having cervicocranial syndrome. Treatment to date has included acupuncture (35 sessions), rhizotomies between C4-7, trigger point injections at C4-7, 2 epidural injections, medication, psychiatry care, ice, transcutaneous electrical nerve stimulation (TENS) unit. X-Rays results were reported on 7/9/14 report C5-6 disc space narrowing, C3 retrolisthesis, and spondylosis. Currently, the injured worker complains of aching, throbbing, stabbing cervical pain with pain into the upper extremities (R>L) with intermittent shooting pain down bilateral upper extremities to elbow with pins and needles into bilateral hands and fingers. There was also frequent headaches, urinary urgency, stomach pain, and thoughts of hurting himself/others. Per the primary physician's progress report (PR-2) on 4/27/15, examination revealed antalgic gait, normal heel and toe walk, cervical flexion of 30/50 degrees, bilateral lateral 20/45 degrees, bilateral lateral rotation at 40/80 degrees, sensation diminished at bilateral C6 and right C7 dermatomes, trace reflexes in bilateral biceps, brachioradialis, and triceps, positive Tinel's bilaterally at the wrist, positive Spurling's on right to the tip of the shoulder. Current plan of care included discussion of treatment therapy, injections or surgery, activity modification and home exercise program and medial branch block. The requested treatments include Bilateral C4-5, C5-6, C6-7 Medial Branch Block.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral C4-5, C5-6, C6-7 Medial Branch Block: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MBB. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Medial branch blocks (MBBs).<http://www.odg-twc.com/index.html>.

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." 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 that 2 level facet injections at one session are authorized by the guidelines. In addition, a superimposed cervical radiculopathy is not excluded. Therefore, the request for Bilateral C4-5, C5-6, C6-7 Medial Branch Block is not medically necessary.