

Case Number:	CM13-0049629		
Date Assigned:	12/27/2013	Date of Injury:	09/30/2001
Decision Date:	06/17/2014	UR Denial Date:	10/23/2013
Priority:	Standard	Application Received:	11/08/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 73 year old female with a date of injury on September 30, 2001. It was reported that the injured employee is retired, permanent and stationary as of August, 2002. The injured worker's diagnoses include cervical radiculopathy, cervical degenerative disc disease at C5-C6 and C6-C7, and failed total knee replacement. The patient has had conservative treatment with physical therapy. Medications prescribed have included Neurontin, Tylenol #4 and a Lidoderm patch. The disputed request is for 3 levels of cervical facet injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT C2-C3, C3-C4, AND C4-C5 FACET INJECTIONS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation NECK AND UPPER BACK COMPLAINTS, facet joint therapeutic steroid injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, Facet Injections.

Decision rationale: Cervical facet injections are not specifically addressed within the Chronic Pain Medical Treatment Guidelines. However, Section 9792.23.1 Neck and Upper Back Complaints states the following: "The Administrative Director adopts and incorporates by reference the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd

Edition (2004), Chapter 8) into the MTUS from the ACOEM Practice Guidelines." ACOEM Chapter 8 page 174-175 states that "Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints, or corticosteroids, Lidocaine, or opioids in the epidural space have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injections may help patients presenting in the transitional phase between acute and chronic pain." In Table 8-8 (Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints), there is recommendation against "facet injection of corticosteroids (D)." The Official Disability Guidelines specify in the Neck Chapter that cervical facet injections are "not recommended. Intra-articular blocks: No reports from quality studies regarding the effect of intra-articular steroid injections are currently known. There are also no comparative studies between intra-articular blocks and rhizotomy. (Falco, 2009) (van Eerd, 2010) There is one randomized controlled study evaluating the use of therapeutic intra-articular corticosteroid injections. The results showed that there was no significant difference between groups of patients (with a diagnosis of facet pain secondary to whiplash) that received corticosteroid vs. local anesthetic intra-articular blocks (median time to return of pain to 50%, 3 days and 3.5 days, respectively). (Barnsley, 1994) 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. (Manchikanti, 2008) 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. (van Eerd, 2010) (Nelemans-Cochrane, 2000) (Manchikanti, 2004) (Manchikanti, 2003) (Boswell, 2007) (Falco, 2009) (Manchikanti, 2008) (Manchikanti, 2009) (Carragee, 2009) While not recommended, criteria for use of therapeutic intra-articular and medial branch blocks, if used anyway are below. 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 the case of this request, more than 2 levels are requested. Furthermore, there is documentation of cervical radiculopathy, which violates Criteria #1 of the Official Disability Guidelines. Given this factors, this request is not medically necessary at this time.