

<b>Case Number:</b>	CM14-0215835		
<b>Date Assigned:</b>	01/05/2015	<b>Date of Injury:</b>	11/19/2013
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### 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 Patient is a 66-year-old man who sustained a work-related injury on November 19, 2013. Subsequently, the patient developed chronic neck pain. According to a progress report dated October 1, 2014, the patient complained of daily head pain with onset at the left sub occipital region and radiation to the hemicrania. The patient stated that the pain was exacerbated with neck movement. In addition, he reported neck stiffness, better cognition and memory. The patient rated the lseverity of his pain as a 4/10. Upon examination, the patient exhibited left sub occipital tenderness with neck limited range of motion. treatments rendered included a neck injection with steroid and lidocaine. In a letter dated November 26, 2014, the patient stated that after the injection, he had headaches for about 2 weeks. they stopped for 2 weeks and then returned at a frequency of 2-3 per week.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One 2nd cervical nerve block injection and a follow-up visit:** 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) Pain, Chronic

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 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, 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. There is no clear evidence that cervical facets are the main pain generators and the number of requested levels to be blocked is not documented. In addition, a superimposed radiculopathy cannot be excluded. Therefore, the request is not medically necessary.