

Case Number:	CM14-0216287		
Date Assigned:	01/06/2015	Date of Injury:	01/10/2014
Decision Date:	03/06/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	12/24/2014

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: Ohio, North Carolina, Virginia
Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 54 year old male continues to complain of upper back, left shoulder and left side neck pain and headaches stemming from a work related pulling injury reported on 1/10/2014. Diagnoses include: shoulder/arm sprain; cervicgia with strained left trapezius muscle and herniated left cervical disc at C5-6; right cervical 3-4 stenosis with marked narrowing and diffuse arthritis (with symptoms starting on the right); and left cervical radiculopathy. Treatments have included: consultations; diagnostic imaging studies; failed physical therapy; cervical epidural block; a home stretching exercise program; psychiatric treatments; and medication management. The injured worker (IW) is noted to be on restricted work duties but unable to work due to debilitating pain. Progress notes, of 7/21/2014 and 7/22/2014, note the IW feeling miserable with pain in the mid-cervical spine, having his medications denied and resulting in the IW being unable to return to modified duties at work. Also noted were complications with this claim due to a history of heart issues, and failed physical therapy. The treatment plans included finishing up the cervical epidural block in hopes of relief, as well as a discussion about consideration of diagnostic/therapeutic fluoroscopically guided zygapophyseal joint injections. Primary physician progress notes, dated 10/2/2014, note pain with resisted shoulder abduction and scapular retraction, mild restriction with rotation of the neck and affected left side with positive Spurling with no radicular symptoms at that time; but is unable to return to work due to debilitating pain. Secondary treating physician progress notes, dated 10/28/2014, note complaints of headaches with left upper back pain and back spasms. The impression noted intermittent left arm paresthesia's and a history for which physical therapy aggravated symptoms; and an MRI that

noted age-appropriate spondylosis without focal disk protrusion neural compromise, but having some zygapophyseal joint hypertrophic changes; and wanting to rule out zygapophyseal joint pain. The treatment plan included modifying physical therapy to concentrate on stretching and spine stabilization, and with caution on any manipulation therapy; maximize stretching; and therapeutic/diagnostic left cervical facet joint injection series. On 11/24/2014 Utilization Review non-certified, for medical necessity, a request for therapeutic left cervical (C) 4-5, C5-6 & C6-7 Fluoroscopic Guided Facet Block Injections, 1 injection for each of the 3 sections, citing that the ODG guidelines for treatment of the Neck and Upper Back (Acute & Chronic), which recommend certain Facet treatments when criteria is met for a maximum of 2 spinal levels; and that currently cervical intra-articular blocks are not recommended. This was followed up by a recommendation for a more appropriate treatment for diagnostic medical branch blocks at 2 spinal levels.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left C4-5 Fluoroscopic Guided Facet Block Injection: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Facet joint pain, signs & symptoms and Facet joint diagnostic blocks.

Decision rationale: The cause of facet joint pain is largely unknown although pain is generally thought to be secondary to either trauma or a degenerative process. Traumatic causes include fracture and/or dislocation injuries and whiplash injuries, with the most common cervical levels involved in the latter at C2-3 and C5-6. The condition has been described as both acute and chronic, and includes symptoms of neck pain, headache, shoulder pain, suprascapular pain, scapular pain, and upper arm pain. Symptoms: The most common symptom is unilateral pain that does not radiate past the shoulder. (van Eerd, 2010) Physical findings: Signs in the cervical region are similar to those found with spinal stenosis, cervical strain, and diskogenic pain. Characteristics are generally described as the following: (1) axial neck pain (either with no radiation or rarely past the shoulders); (2) tenderness to palpation in the paravertebral areas (over the facet region); (3) decreased range of motion (particularly with extension and rotation); & (4) absence of radicular and/or neurologic findings. If radiation to the shoulder is noted pathology in this region should be excluded. Diagnosis: There is no current proof of a relationship between radiologic findings and pain symptoms. The primary reason for imaging studies is to rule out a neurological etiology of pain symptoms. Diagnosis is recommended with a medial branch block at the level of the presumed pain generator/s. Criteria for the use of diagnostic blocks for facet nerve pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine. 2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the

procedure for at least 4-6 weeks.4. No more than 2 joint levels are injected in one session (see above for medial branch block levels).5. Recommended volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy.6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.7. Opioids should not be given as a (sedative) during the procedure.8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated.11. Blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. In this instance, the history and physical are consistent with facet joint pain. As facet blocks are only allowed 2 levels at a time and given that the pain is localized to the mid-neck, it seems medically reasonable to select the 2 cervical facet joint levels that most closely approximate the mid-neck. Therefore, a left C4-5 fluoroscopic guided facet block injection is medically necessary.

Left C5-6 Fluoroscopic Guided Facet Block Injection: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Facet joint pain, signs & symptoms and Facet joint diagnostic blocks.

Decision rationale: The cause of facet joint pain is largely unknown although pain is generally thought to be secondary to either trauma or a degenerative process. Traumatic causes include fracture and/or dislocation injuries and whiplash injuries, with the most common cervical levels involved in the latter at C2-3 and C5-6. The condition has been described as both acute and chronic, and includes symptoms of neck pain, headache, shoulder pain, suprascapular pain, scapular pain, and upper arm pain. Symptoms: The most common symptom is unilateral pain that does not radiate past the shoulder. (van Eerd, 2010) Physical findings: Signs in the cervical region are similar to those found with spinal stenosis, cervical strain, and diskogenic pain. 2. Tenderness to palpation in the paravertebral areas (over the facet region); (3) decreased range of motion (particularly with extension and rotation); & (4) absence of radicular and/or neurologic findings. If radiation to the shoulder is noted pathology in this region should be excluded. Diagnosis: There is no current proof of a relationship between radiologic findings and pain symptoms. The primary reason for imaging studies is to rule out a neurological etiology of pain symptoms. Diagnosis is recommended with a medial branch block at the level of the presumed pain generator/s. Criteria for the use of diagnostic blocks for facet nerve pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial

branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine.2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally.3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.4. No more than 2 joint levels are injected in one session (see above for medial branch block levels).5. Recommended volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy.6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.7. Opioids should not be given as a (sedative) during the procedure.8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated.11. Blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. In this instance, the history and physical are consistent with facet joint pain. As facet blocks are only allowed 2 levels at a time and given that the pain is localized to the mid-neck, it seems medically reasonable to select the 2 cervical facet joint levels that most closely approximate the mid-neck. Therefore, a left C5-6 fluoroscopic guided facet block injection is medically necessary.

Left C6-7 Fluoroscopic Guided Facet Block Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Facet joint pain, signs & symptoms and Facet joint diagnostic blocks.

Decision rationale: The cause of facet joint pain is largely unknown although pain is generally thought to be secondary to either trauma or a degenerative process. Traumatic causes include fracture and/or dislocation injuries and whiplash injuries, with the most common cervical levels involved in the latter at C2-3 and C5-6. The condition has been described as both acute and chronic, and includes symptoms of neck pain, headache, shoulder pain, suprascapular pain, scapular pain, and upper arm pain. Symptoms: The most common symptom is unilateral pain that does not radiate past the shoulder. (van Eerd, 2010) Physical findings: Signs in the cervical region are similar to those found with spinal stenosis, cervical strain, and diskogenic pain. (2) tenderness to palpation in the paravertebral areas (over the facet region); (3) decreased range of motion (particularly with extension and rotation); & (4) absence of radicular and/or neurologic findings. If radiation to the shoulder is noted pathology in this region should be excluded. Diagnosis: There is no current proof of a relationship between radiologic findings and pain symptoms. The primary reason for imaging studies is to rule out a neurological etiology of pain

symptoms. Diagnosis is recommended with a medial branch block at the level of the presumed pain generator/s. Criteria for the use of diagnostic blocks for facet nerve pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine. 2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a (sedative) during the procedure. 8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. 11. Blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. 12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. In this instance, the history and physical are consistent with facet joint pain. As facet blocks are only allowed 2 levels at a time and given that the pain is localized to the mid-neck, it seems medically reasonable to select the 2 cervical facet joint levels that most closely approximate the mid-neck. Therefore, since facet joint injections have already been approved at two levels, C4-5 and C5-6, a left C6-7 fluoroscopic guided facet block injection is not medically necessary at this time.