

Case Number:	CM15-0014118		
Date Assigned:	02/02/2015	Date of Injury:	06/16/2014
Decision Date:	03/19/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	01/26/2015

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: Arizona, California
 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:

The injured worker was a 58 year old female, who sustained an industrial injury, June 16, 2014. The injury occurred after lifting some heavy boxes for archive files. The lifting caused the injured worker to have increased pain in the neck. The injured worker was diagnosed with bursitis necrosis and cervical spondylosis. The injured worker previously received the following treatments chiropractic services, acupuncture, right trochanteric bursa injection on the right side with ultrasound was completed in the office. The injured worker was started on Baclofen, Neurontin, Mobic, biofeedback, 6 physical therapy sessions, 6 acupuncture sessions and psychological intervention. According to progress note of December 1, 2014, the injured workers chief complaint was pain in the right side of the neck cause radiating and shooting pain into the sub-occipital region and causing a headache with increased pain with neck rotation. On December 1, 2014, the primary treating physician requested cervical facet medial branch block C3-C5 right side then left side to be done a separate days with fluoroscopy and anesthesia. January 15, 2015, the utilization review denied authorization for cervical facet medial branch block C3-C5 right side then left side to be done a separate days with fluoroscopy and anesthesia. The utilization Reviewer referenced MTUS/ACOEM and ODG guidelines for the decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical facet medial branch block C3-C5 right side then left side to be done separate days with fluroscopy and anesthesia: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Signs and Symptoms cervical

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medial branch and facet blocks

Decision rationale: According to the guidelines, a medial branch block may be performed prior to a facet neurotomy(which is currently under study) for diagnostic purposes. The criteria for an MBB is as follows: 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 responseshould 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 andNSAIDs) 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 isanticipated. 11. Diagnostic facet 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. The progress note on 1/7/15 indicated this block would be used for diagnostic purposes with intention of doing a radiofrequency ablation. However, since facet joint radiofrequency ablation is under study and not currently considered a medical necessity, the medial branch block is not medically necessary.