

Case Number:	CM15-0173692		
Date Assigned:	09/15/2015	Date of Injury:	11/19/2012
Decision Date:	10/19/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	09/03/2015

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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 56 year old female, who sustained an industrial-work injury on 11-19-12. She reported initial complaints of right shoulder pain. The injured worker was diagnosed as having cervical spondylosis, cervical disc degeneration, possible-probable labral tear of the right shoulder, osteoarthritis of shoulder. Treatment to date has included medication, surgery (bilateral knee replacements, arthroscopic shoulder surgery, lumbar surgery, cervical interlaminar epidural steroid injection, and medial branch block), physical therapy, diagnostics, and home exercise program. MRI results of the cervical spine were reported on 4-25-14 noted reversal of the cervical lordosis, cervical spondylosis without significant central spinal stenosis or cord compression, moderate to severe narrowing of the left C3-4 and moderate narrowing of the right C5-6 neural foramina. Currently, the injured worker complains of neck and upper back pain rated 4 out of 10 and described as dull, aching, sharp shooting, and alleviated by rest and medication. There was a good response to the recent cervical medial branch block injection. Per the primary physician's progress report (PR-2) on 7-6-15, exam notes tender mid cervical spine and radiating to the right shoulder pain. The Request for Authorization date requested service to include Right C3 medial branch block, Right C4 medial branch block, and Right C5 medial branch block. The Utilization Review on 8-11-15 denied the request due to guidelines not supporting a second set of injections, and if positive diagnostic, they are to be followed by radiofrequency ablation. The available information does not support the medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right C3 medial branch block: 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), Low Back Chapter, Medial branch blocks.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter/Facet Joint Diagnostic Blocks Section.

Decision rationale: The MTUS Guidelines do not recommend the use of cervical facet joint injections. Per the ODG cervical diagnostic facet injections are recommended prior to facet neurotomy (a procedure that is considered "under study"). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBB. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 27% to 63%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. In this case, the injured worker has had a previous diagnostic block on 6/15/15 with positive results. There is rationale included in the available documentation to obtain a second set of medial branch blocks as the next step would include facet neurotomy. The request for right C3 medial branch block is determined to not be medically necessary.

Right C5 medial branch block: 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), Low Back Chapter, Medial branch blocks.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter/Facet Joint Diagnostic Blocks Section.

Decision rationale: The MTUS Guidelines do not recommend the use of cervical facet joint injections. Per the ODG cervical diagnostic facet injections are recommended prior to facet neurotomy (a procedure that is considered "under study"). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of

placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBB. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 27% to 63%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. In this case, the injured worker has had a previous diagnostic block on 6/15/15 with positive results. There is rationale included in the available documentation to obtain a second set of medial branch blocks as the next step would include facet neurotomy. The request for right C5 medial branch block is determined to not be medically necessary.

Right C4 medial branch block: 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), Low Back Chapter, Medial branch blocks.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter/Facet Joint Diagnostic Blocks Section.

Decision rationale: The MTUS Guidelines do not recommend the use of cervical facet joint injections. Per the ODG cervical diagnostic facet injections are recommended prior to facet neurotomy (a procedure that is considered "under study"). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBB. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 27% to 63%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. In this case, the injured worker has had a previous diagnostic block on 6/15/15 with positive results. There is rationale included in the available documentation to obtain a second set of medial branch blocks as the next step would include facet neurotomy. The request for right C4 medial branch block is determined to not be medically necessary.