

Case Number:	CM15-0174307		
Date Assigned:	09/16/2015	Date of Injury:	08/31/2009
Decision Date:	10/23/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	09/04/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 34-year-old female, who sustained an industrial injury, August 31, 2009. According to progress note of March 5, 2015, the injured worker's chief complaint was neck pain. The pain was rated at 8 out of 10 after a left C3-C4 and C4-C5 facet injection with fluoroscopy and conscious on February 3, 2015, cervical radiofrequency ablation with moderate sedation and fluoroscopy on February 13, 2015. According to progress note of July 29, 2015, the injured worker's chief complaint was neck pain. The injured worker described the neck pain as burning on the right side in the trapezii. The pain on the left side was a stabbing and aching pain. The pain was rated at 5 out of 10 without medications and 4 out of 10 with pain medications. The injured worker had increased pain with sitting, standing, walking, bending and lifting. The physical exam noted 5 out of 5 upper extremity strength. The deep tendon reflexes were 2 plus and symmetric. The Spurling's sign was negative bilaterally. There was tenderness over the facet cervical joints at the bilateral C3-C4 and C4-C5 right more than the left. There was tenderness over the cervical paraspinals. Myofascial restrictions were appreciated. The cervical range of motion was slightly reduced with lateral bend bilaterally. The injured worker was undergoing treatment for chronic neck pain, cervical facet disease, and cervical degenerative disc disease and cervical spondylosis. The injured worker previously received the following treatments left C3-C4 and C4-C5 facet injection with fluoroscopy and conscious on February 3, 2015, cervical radiofrequency ablation with moderate sedation and fluoroscopy on February 13, 2015 only lasted one week before symptoms started returning, Tramadol, Naproxen and Colace for constipation. The RFA (request for authorization) dated July 29, 2015: the following treatments

were requested left C3-C4 and C4-C5 facet injection with fluoroscopy and conscious. The UR (utilization review board) denied certification on August 8, 2015, for the left C3-C4 and C4-C5 facet injection with fluoroscopy and conscious, due to ODG did not recommend conscious sedation for diagnostic facet injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left C3-4 Facet Injection with Fluoroscopy and Conscious Sedation QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Work Loss Data Institute Treatment in Workers Compensation (TWC), Diagnostic Blocks (Acute & Chronic), Facet Joint Medial Branch Blocks.

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 Diagnostic Blocks.

Decision rationale: Per the ODG Guidelines with regard to facet joint diagnostic blocks: 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. 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. 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, stellate ganglion blocks, or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. The medical records submitted for review indicate that the injured worker has previously undergone cervical facet injections 2/3/15, as well as cervical radiofrequency ablation 2/13/15 which only provided relief for one week before symptoms started returning. As the guidelines only recommend facet injections for diagnostic purposes, and the injured worker has already undergone facet injections, the request is not medically necessary. Furthermore, subsequent neurotomy was not medically necessary.

Left C4-5 Facet Injection with Fluoroscopy and Conscious Sedation QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Work Loss Data Institute Treatment in Workers Compensation (TWC), Diagnostic Blocks (Acute & Chronic), Facet Joint Medial Branch Blocks.

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 Diagnostic Blocks.

Decision rationale: Per the ODG Guidelines with regard to facet joint diagnostic blocks: 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. 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. 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, stellate ganglion blocks, or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. The medical records submitted for review indicate that the injured worker has previously undergone cervical facet injections 2/3/15, as well as cervical radiofrequency ablation 2/13/15 which only provided relief for one week before symptoms started returning. As the guidelines only recommend facet injections for diagnostic purposes, and the injured worker has already undergone facet injections, the request is not medically necessary. Furthermore, subsequent neurotomy was not medically necessary.