

<b>Case Number:</b>	CM15-0178288		
<b>Date Assigned:</b>	09/22/2015	<b>Date of Injury:</b>	05/31/2006
<b>Decision Date:</b>	11/02/2015	<b>UR Denial Date:</b>	08/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2015

### 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 is a 53 year old male with an industrial injury dated 05-31-2006. A review of the medical records indicates that the injured worker is undergoing treatment for ruling out left cervical facet mediated pain, status post cervical fusion at C5-6 and left rotator cuff tear repair. Treatment has included diagnostic studies, prescribed medications, cervical medial branch block and periodic follow up visits. According to the progress note dated 08-18-2015, the injured worker reported neck pain and left shoulder pain with frequent dislocation 3-4 times a week and chronic headaches. Records (08-18-2015) indicated that the injured worker had a cervical medial branch block to test cervical facets on the left side. The injured worker reported 90% relief of neck pain with improvement in range of motion. The injured worker also reported that he hasn't had much range of motion for ten years. Objective findings (8-18-2015) revealed myofascial tenderness of upper trapezius, limited cervical range of motion, and very limited left cervical rotation. The treatment plan included authorization of a 2nd set of confirmatory cervical medial branch block to test left C4-5, C6-7 facet joints. The injured worker's work status is temporary total disability. The original utilization review determination (08-26-2015) non-certified the request for second left cervical medial branch blocks C4-5 and additional level C6-7.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Second left cervical medial branch blocks C4-5 and additional level C6-7: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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. Per progress report dated 8/18/15 it was noted that the injured worker underwent cervical medial branch blocks to test cervical joints on the left side, which resulted in 90% pain improvement. As the guidelines do not support repeat medial branch blocks and instead recommend progressing to neurotomy, the request is not medically necessary.