MAXIMUS Federal Services

Case Number:	CM15-0090730		
Date Assigned:	05/15/2015	Date of Injury:	09/21/2009
Decision Date:	07/01/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/11/2015

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: Physical Medicine & Rehabilitation

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 50 year old female injured worker suffered an industrial injury on 09/21/2009. The diagnoses included cervical musculoligamentous sprain/strain and bilateral upper extremity radiculitis. The diagnostics included cervical magnetic resonance imaging and electromyographic studies/nerve conduction velocity studies. The injured worker had been treated with home exercise program. On 4/16/2015 the treating provider reported cervical spine tenderness with muscle guarding and spasms along with reduced range of motion. The neck pain was increasing was rated as 8 to 9/10 and was moderate to severe. The treatment plan included cervical medial branch block injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right C5 medial branch block injection, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (Acute & Chronic), Facet joint diagnostic blocks.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 300-301,174-175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, facet joint injections.

Decision rationale: Based on the 4/16/15 progress report provided by the treating physician, this patient presents with gradually worsening neck pain rated 8-9/10 on VAS scale that is frequent and constant. The treater has asked for Right C5 Medial Branch Block Injection Qty 1 on 4/16/15. The patient's diagnoses per request for authorization form dated 4/16/15 are cervical musculoligamentous s/s and bilateral upper extremity radiculitis, left side greater than right with degenerative disc disease/spurring at C4-5, C5-6 and C6-7, per X-rays dated December 5, 2012 and three-milimeter disc protrusions at C4-5 and C6-7 with mild to moderate central canal narrowing with multilevel degenerative changes, per MRI scan dated October 1, 2013; EMG/NCV of the bilateral upper extremities dated October 17, 2013 is negative for radiculopathy, thoracic muscloligamentous s/s, and psychiatric complaints, deferred to [redacted] The patient is s/p home exercise program, acupuncture treatment, electrical stimulation unit. The patient had a flare up of her neck pain per 1/8/15 report. The patient had 2 prior epidural steroid injection at unspecified location, in March and April of 2014 with 70% improvement of radicular numbness/tingling per 9/24/14 report. There is no documentation of prior medial branch blocks per reports dated 9/24/14 to 4/16/15. The patient is currently working per 4/16/15 report. MTUS/ACOEM Neck Complaints, Chapter 8, page 174-175, under Initial Care states: for Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints, or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injections may help patients presenting in the transitional phase between acute and chronic pain. ODG-TWC, Neck and Upper Back Chapter, under Facet joint diagnostic blocks states: 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. 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.For facet joint pain signs and symptoms, the ODG guidelines state that physical examination findings are generally described as: 1. axial pain, either with no radiation or severity 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; and 4. absence of radicular and/or neurologic findings. In regard to the request for a cervical facet block at right C5 level, the patient does not meet guideline criteria for such an injection. Documentation provided does not indicate that this patient has prior facet joint injections or fusions at the requested levels, and there is no evidence that this patient is anticipating surgical intervention. However, this patient presents with cervical pain, which radiates into the bilateral upper extremities. Guidelines do not support diagnostic

cervical facet blocks in patients who present with radicular cervical pain. Given these findings, the requested diagnos tic block cannot be substantiated. The request is not medically necessary.

Left C5 medial branch block injection, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (Acute & Chronic), Facet joint diagnostic blocks.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 300-301,174-175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, facet joint injections.

Decision rationale: Based on the 4/16/15 progress report provided by the treating physician, this patient presents with gradually worsening neck pain rated 8-9/10 on VAS scale that is frequent and constant. The treater has asked for Left C5 Medial Branch Block Injection Qty 1 on 4/16/15. The patient's diagnoses per request for authorization form dated 4/16/15 are cervical musculoligamentous s/s and bilateral upper extremity radiculitis, left side greater than right with degenerative disc disease/spurring at C4-5, C5-6 and C6-7, per X-rays dated December 5, 2012 and three-milimeter disc protrusions at C4-5 and C6-7 with mild to moderate central canal narrowing with multilevel degenerative changes, per MRI scan dated October 1, 2013; EMG/NCV of the bilateral upper extremities dated October 17, 2013 is negative for radiculopathy, thoracic muscloligamentous s/s, and psychiatric complaints, deferred to [redacted] The patient is s/p home exercise program, acupuncture treatment, electrical stimulation unit. The patient had a flare up of her neck pain per 1/8/15 report. The patient had 2 prior epidural steroid injection at unspecified location, in March and April of 2014 with 70% improvement of radicular numbness/tingling per 9/24/14 report. The patient is currently working per 4/16/15 report. MTUS/ACOEM Neck Complaints, Chapter 8, page 174-175, under Initial Care states: for Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints, or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injections may help patients presenting in the transitional phase between acute and chronic pain.ODG-TWC, Neck and Upper Back Chapter, under Facet joint diagnostic blocks states: 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. 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.For facet joint pain signs and symptoms, the ODG guidelines state that physical examination findings are generally

described as: 1. axial pain, either with no radiation or severity 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; and 4. absence of radicular and/or neurologic findings. In regard to the request for a cervical facet block at left C5 level, the patient does not meet guideline criteria for such an injection. Documentation provided does not indicate that this patient has prior facet joint injections or fusions at the requested levels, and there is no evidence that this patient is anticipating surgical intervention. However, this patient presents with cervical pain, which radiates into the bilateral upper extremities. Guidelines do not support diagnostic cervical facet blocks in patients who present with radicular cervical pain. Given these findings, the requested diagnostic block cannot be substantiated. The request is not medically necessary.

Right C7 medial branch block injection, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (Acute & Chronic), Facet joint diagnostic blocks.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 300-301,174-175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, facet joint injections.

Decision rationale: Based on the 4/16/15 progress report provided by the treating physician, this patient presents with gradually worsening neck pain rated 8-9/10 on VAS scale that is frequent and constant. The treater has asked for Right C7 Medial Branch Block Injection Qty 1 on 4/16/15. The patient's diagnoses per request for authorization form dated 4/16/15 are cervical musculoligamentous s/s and bilateral upper extremity radiculitis, left side greater than right with degenerative disc disease/spurring at C4-5, C5-6 and C6-7, per X-rays dated December 5, 2012 and three-milimeter disc protrusions at C4-5 and C6-7 with mild to moderate central canal narrowing with multilevel degenerative changes, per MRI scan dated October 1, 2013; EMG/NCV of the bilateral upper extremities dated October 17, 2013 is negative for radiculopathy, thoracic muscloligamentous s/s, and psychiatric complaints, deferred to [redacted] The patient is s/p home exercise program, acupuncture treatment, electrical stimulation unit. The patient had a flare up of her neck pain per 1/8/15 report. The patient had 2 prior epidural steroid injection at unspecified location, in March and April of 2014 with 70% improvement of radicular numbness/tingling per 9/24/14 report. The patient is currently working per 4/16/15 report. MTUS/ACOEM Neck Complaints, Chapter 8, page 174-175, under Initial Care states: for Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints, or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injections may help patients presenting in the transitional phase between acute and chronic pain.ODG-TWC, Neck and Upper Back Chapter, under Facet joint diagnostic blocks states: 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. 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.For facet joint pain signs and symptoms, the ODG guidelines state that physical examination findings are generally described as: 1. axial pain, either with no radiation or severity 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; and 4. absence of radicular and/or neurologic findings. In regard to the request for a cervical facet block at right C7 level, the patient does not meet guideline criteria for such an injection. Documentation provided does not indicate that this patient has prior facet joint injections or fusions at the requested levels, and there is no evidence that this patient is anticipating surgical intervention. However, this patient presents with cervical pain, which radiates into the bilateral upper extremities. Guidelines do not support diagnostic cervical facet blocks in patients who present with radicular cervical pain. Given these findings, the requested diagnostic block cannot be substantiated. The request is not medically necessary.

Left C7 medial branch block injection, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (Acute & Chronic), Facet joint diagnostic blocks.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 300-301,174-175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, facet joint injections.

Decision rationale: Based on the 4/16/15 progress report provided by the treating physician, this patient presents with gradually worsening neck pain rated 8-9/10 on VAS scale that is frequent and constant. The treater has asked for LEFT C7 MEDIAL BRANCH BLOCK QTY 1on 4/16/15. The patient's diagnoses per request for authorization form dated 4/16/15 are cervical musculoligamentous s/s and bilateral upper extremity radiculitis, left side greater than right with degenerative disc disease/spurring at C4-5, C5-6 and C6-7, per X-rays dated December 5, 2012 and three-milimeter disc protrusions at C4-5 and C6-7 with mild to moderate central canal narrowing with multilevel degenerative changes, per MRI scan dated October 1, 2013; EMG/NCV of the bilateral upper extremities dated October 17, 2013 is negative for radiculopathy, thoracic muscloligamentous s/s, and psychiatric complaints, deferred to [redacted] The patient is s/p home exercise program, acupuncture treatment, electrical stimulation unit. The patient had a flare up of her neck pain per 1/8/15 report. The patient had 2 prior epidural steroid injection at unspecified location, in March and April of 2014 with 70% improvement of radicular numbness/tingling per 9/24/14 report. The patient is currently working per 4/16/15 report. MTUS/ACOEM Neck Complaints, Chapter 8, page 174-175, under Initial Care states: for Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of

trigger points, facet joints, or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injections may help patients presenting in the transitional phase between acute and chronic pain.ODG-TWC, Neck and Upper Back Chapter, under Facet joint diagnostic blocks states: 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. 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. For facet joint pain signs and symptoms, the ODG guidelines state that physical examination findings are generally described as: 1. axial pain, either with no radiation or severity 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; and 4. absence of radicular and/or neurologic findings. In regard to the request for a cervical facet block at left C7 level, the patient does not meet guideline criteria for such an injection. Documentation provided does not indicate that this patient has prior facet joint injections or fusions at the requested levels, and there is no evidence that this patient is anticipating surgical intervention. However, this patient presents with cervical pain, which radiates into the bilateral upper extremities. Guidelines do not support diagnostic cervical facet blocks in patients who present with radicular cervical pain. Given these findings, the requested diagnostic block cannot be substantiated. The request is not medically necessary.