

<b>Case Number:</b>	CM15-0091126		
<b>Date Assigned:</b>	05/15/2015	<b>Date of Injury:</b>	08/11/2005
<b>Decision Date:</b>	06/24/2015	<b>UR Denial Date:</b>	04/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2015

### 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:

Certification(s)/Specialty:

### 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 63 year old female with an industrial injury dated 8/11/2005. The injured worker's diagnoses include cervicalgia, cervical spinal stenosis, cervical neuritis and myalgia and myositis. Treatment consisted of Magnetic Resonance Imaging (MRI) of the cervical spine, Electromyography (EMG)/ Nerve conduction studies (NCS), prescribed medications, epidural steroid injection (ESI) and periodic follow up visits. In a progress note dated 4/15/2015, the injured worker reported neck pain rated a 3/10. The injured worker reported that her medications have been providing more than 50% pain relief. Objective findings revealed mild tenderness in the posterior cervical spine and paraspinals with mild paravertebral muscle tightness on the left. Mild decrease in the dermatomal distribution of the C8-T1 on the left was also noted on exam. The treating physician reported that the MRI of the cervical spine revealed discogenic changes/bulges at C5-6, C6-7 and C7-T1. EMG/NCS revealed C8-T1 active radiculopathy, possibly C7. The treating physician prescribed services for cervical facet injection, C2-C3, C3-C4, with fluoroguide and moderate sedation, outpatient and follow up visit now under review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical facet injection, C2-C3, C3-C4, with fluoroguide and moderate sedation, outpatient:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298. Decision based on Non-MTUS Citation Official Disability Guidelines: Criteria for use of diagnostic facet blocks.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, Facet joint injections.

**Decision rationale:** Pursuant to the ACOEM and the Official Disability Guidelines, cervical facet injection, C2 - C3 and C3 - C4 under fluoroscopy with moderate sedation (outpatient) is not medically necessary. The ACOEM does not recommend facet injections of steroids or diagnostic blocks. (Table 8 - 8) Invasive techniques (local injections and facet joint injections of cortisone lidocaine) are of questionable merit. The criteria for use of diagnostic blocks for facet mediated pain include, but are not limited to, patients with cervical pain that is non-radicular and that no more than two levels bilaterally; documentation of failure of conservative treatment (home exercises, PT, non-steroidal anti-inflammatory drugs) prior to procedure at least 4 to 6 weeks; no more than two facet joint levels are injected in one session; etc. There is no evidence-based literature to make a firm recommendation as to sedation during the SI. The use of sedation introduces potential diagnostic and safety issues making it unnecessary than ideal. A major concern is that sedation may result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. Routine use is not recommended except for patients with anxiety. The general agent recommended is a benzodiazepine. While sedation is not recommended for facet injections (especially with opiates) because it may alter the anesthetic diagnostic response, sedation is not generally necessary for an epidural steroid injection is not contraindicated. As far as monitored anesthesia administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of postoperative care. In this case, the injured worker's working diagnoses are cervicalgia, cervical spine stenosis, myalgia and myositis, cervical neuritis. The documentation medical record indicates the injured worker received multiple cervical epidural steroid injections. The documentation indicates the injured worker received 50% pain relief, but no timeframe/duration for pain relief. Progress note dated February 12, 2015 states the injured worker is four months status post ESI with 60% improved pain. On March 17, 2015, a left paramedian cervical ESI was performed. The treating provider stated "the next step is an injection of the upper cervical facets". There is no clinical rationale for the upper cervical facet injection (next step). An April 15, 2015 note states the epidural steroid injection provided 50% pain relief with no duration. Subjectively, according to an April 15 progress note, the injured worker had a 50% decrease in pain, the VAS pain scale is 3/10. Objectively, the cervical spine is tender to palpation bilaterally. Motor strength is not documented and sensory shows a mild decrease in the dermatomal distribution C8-T1 on the left. Facet joint injections are indicated when pain is non-radicular. Sedation is not recommended for facet joint injections because it may alter the anesthetic diagnostic response. Consequently, absent clinical documentation of non-radicular symptoms and guidelines non-recommendations for sedation, cervical facet injection, C2 - C3 and C3 - C4 under fluoroscopy with moderate sedation (outpatient) is not medically necessary.

**Follow up visit:** 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) Pain section, Office visit.

**Decision rationale:** Pursuant to the Official Disability Guidelines, follow-up visit is not medically necessary. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines as opiates or certain antibiotics require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. Determination of necessity for an office visit requires individual case review and reassessment being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. In this case, the injured worker's working diagnoses are cervicalgia, cervical spine stenosis, myalgia and myositis, cervical neuritis. The documentation medical record indicates the injured worker received multiple cervical epidural steroid injections. The documentation indicates the injured worker received 50% pain relief, but no timeframe/duration for pain relief. Progress note dated February 12, 2015 states the injured worker is four months status post ESI with 60% improved pain. On March 17, 2015, a left paramedian cervical ESI was performed. The treating provider stated "the next step is an injection of the upper cervical facets". There is no clinical rationale for the upper cervical facet injection (next step). An April 15, 2015 note states the epidural steroid injection provided 50% pain relief with no duration. Subjectively, according to an April 15 progress note, the injured worker had a 50% decrease in pain, the VAS pain scale is 3/10. Objectively, the cervical spine is tender to palpation bilaterally. Motor strength is not documented and sensory shows a mild decrease in the dermatomal distribution C8-T1 on the left. Facet joint injections are indicated when pain is non-radicular. Sedation is not recommended for facet joint injections because it may alter the anesthetic diagnostic response. Absent clinical documentation of non-radicular symptoms and guidelines non-recommendations for sedation, cervical facet injections C2 - C3 and C3 - C4 under fluoroscopy with moderate sedation. The cervical facet injection at C2 - C3 and C3 - C4 under fluoroscopy with moderate sedation is not medically necessary and, as a result, a follow-up visit is not medically necessary.