MAXIMUS Federal Services

Case Number:	CM15-0094099		
Date Assigned:	05/20/2015	Date of Injury:	07/14/2011
Decision Date:	06/22/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/15/2015

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: New Jersey, Alabama, California
Certification(s)/Specialty: Neurology, Neuromuscular 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 50-year-old male, who sustained an industrial injury on 7/14/2011. He reported injury to the right elbow. The injured worker was diagnosed as having cervical spondylosis, and brachial neuritis. Treatment to date has included physical therapy for the shoulder, cervical injections, medications, evaluations, cervical spine surgery (7/23/2013), right elbow surgery (10/3/2013) the request is for a C5-C7, and C7-T1 facet block. On 12/12/2012, he is records as having a last visit on 6/2/2014. He reported being able to return to work. He complained of persistent neck pain and associated numbness of the distal right upper extremity. He rated his pain 5/10, and indicated he takes an occasional narcotic and anti-inflammatory. Examination revealed no localizing neurologic deficit. The treatment plan included facet block injections. On 2/5/2015, the records indicate he was released from care, and returned to work. He was reportedly doing well when he developed recurrent pain of the elbow late last year. This record does not indicate subjective or objective findings in regards to the cervical spine. There are no other medical records available for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

C5-C7, C7-T1 Facet Block: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

Decision rationale: According MTUS guidelines, "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain". According to ODG guidelines regarding facets injections, "Under study. Current evidence is conflicting as to this procedure and at this time, no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti , 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial." Furthermore and according to ODG guidelines, Criteria for use of therapeutic intra-articular and medial branch blocks are as follows: 1. No more than one therapeutic intra- articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time. 5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. The ODG guidelines did not support facet injection for cervical pain in this clinical context. There is no documentation of facet mediated pain or that facets are the main pain generator (on physical examination, there are radicular symptoms and neurological findings). There is no documentation of failure of conservative therapies in this patient. No more that 2 level facet injections at one session are authorized by the guidelines. Therefore, the request for C5-C7, C7- T1 Facet Block is not medically necessary.