

Case Number:	CM15-0095869		
Date Assigned:	05/22/2015	Date of Injury:	01/12/2012
Decision Date:	06/26/2015	UR Denial Date:	05/04/2015
Priority:	Standard	Application Received:	05/18/2015

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:

This 66-year-old male sustained an industrial injury to the neck on 1/12/12. Previous treatment included magnetic resonance imaging, physical therapy, acupuncture, epidural steroid injections, psychotherapy, home exercise and medications. Magnetic resonance imaging cervical spine (10/31/12) showed foraminal stenosis and disc degeneration. Magnetic resonance imaging of the brain (4/29/13) showed a white matter abnormality within the right frontal lobe. In a neurology-psychological supplemental report dated 11/19/14, the physician stated that that the injured worker's right frontal lobe lesion was likely resulting in cognitive impairment and responsible for the injured worker's cognitive issues. In the most recent PR-2 submitted for review, dated 12/19/14, the injured worker complained of neck pain rated 8/10 on the visual analog scale with medications and 10/10 without. The injured worker reported that his quality of sleep was poor and that his activity level had decreased. Physical exam was remarkable for cervical spine with straightening of the spine and loss of normal cervical lordosis, restricted range of motion due to pain, hypertonicity to the paraspinal musculature and trapezius, tenderness to palpation over the bilateral occiput bases, positive Spurling's maneuver and trigger points with radiating pain and twitch response on palpation of the cervical paraspinal and left trapezius muscle. Current diagnoses included cervical spine pain, cervical spine sprain/strain, wrist pain, muscle spasm and cervical spine radiculopathy. The treatment plan included continuing psychotherapy, continuing medications (Flector patch, Robaxin, Norco, Trazadone and Colace) and requesting authorization for trigger point injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial branch block at C4, C5, C6 on the left side: Upheld

Claims Administrator guideline: The Claims Administrator 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.

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. In this case, there is no documentation of failure of conservative therapies in this patient. In addition, the patient underwent a cervical ESI at C7-T1 on June 25, 2014 without evidence of functional improvement and pain relief. Therefore, the request for Medial branch block at C4, C5, and C6 on the left side is not medically necessary.