

<b>Case Number:</b>	CM15-0096065		
<b>Date Assigned:</b>	05/26/2015	<b>Date of Injury:</b>	01/19/1999
<b>Decision Date:</b>	06/24/2015	<b>UR Denial Date:</b>	05/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2015

### 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 (IW) is a 67-year-old female who sustained an industrial injury on 01/19/1999. Diagnoses include cervical radiculopathy, cervical disc disease and cervicgia. Treatment to date has included medications, epidural steroid injections and physical therapy. An MRI of the cervical spine dated 4/2/15 showed C5-C6 right greater than left neural foraminal stenosis, C4-5 and C6-7 right neural foraminal stenosis and cervical facet arthritis at multiple levels. MRIs from 2001 and 2004 were submitted for comparison. According to the treating physician's progress notes dated 3/13/15, the IW reported neck pain that radiated to the shoulder and radial aspect of the right arm including the forearm and thumb. She also reported muscle spasms of the neck. The pain was rated 8/10. On examination, range of motion was limited and Spurling's maneuver did not produce pain in the neck muscles or radicular symptoms in the arms. No sensory deficits were reported. An epidural steroid injection (ESI) at C6-C7 was performed 4/22/15. Progress notes for 5/5/15 stated the radicular arm pain was reduced by 80% after the ESI, which allowed the IW to increase her level of activity. A request was made for C3-C4, C4-C5 and C5-C6 bilateral medial branch blocks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**C3-C4, C4-C5, C5-C6 Medical branch blocks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), facet joint intra-articular injections.

**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."There is no documentation of failure of conservative therapies in this patient. The patient has a working diagnosis of cervical radiculopathy with clear radicular objective findings on examination. In addition, no more than 2 level facet injections at one session are authorized by the guidelines. Therefore, the request for C3-C4, C4-C5, C5-C6 Medical branch blocks is not medically necessary.