Case Number:	CM14-0144243		
Date Assigned:	09/12/2014	**Date of Injury:**	08/13/1999
Decision Date:	10/06/2014	**UR Denial Date:**	08/05/2014
Priority:	Standard	**Application Received:**	09/05/2014

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. The expert reviewer is Board Certified in Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 64-year-old woman who sustained a work-related injury on August 15, 1999. Subsequently, she developed with chronic neck pain. She underwent cervical decompression and fusion at C6 on September 12, 2012. On January 10, 2013, the patient reported pain and burning sensation in both arms and swallowing difficulties which will spontaneously. Her MRI of the C-spine performed on March 17, 2014 demonstrated the stable anterior fusion, degenerative disc disease at the level of C6-7. The electromyography/nerve conduction velocity (EMG/NCV) of both upper extremities performed on April 1, 2014 demonstrated bilateral C5-C6 and VII nerve root impingement. Her physical examination demonstrated no evidence of myelopathy. According to another evaluation performed on June 16, 2014, the patient was complaining of back and neck pain as well as weakness in both arms. The patient reported bladder incontinence. Her physical examination demonstrated the cervical tenderness, decreased sensation to light touch left C6 distribution. The provider requested authorization for facet injections and cervical epidural steroid injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Facet Injection at C2-3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 48, 174, 181. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back

Chapter, Facet Joint Pain, Signs and Symptoms; Facet Joint Diagnostic Blocks; Facet Joint Therapeutic Steroid Injection.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) < Facet Joint Intra-Articular Injections (Therapeutic Blocks) (http://worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#Facetjointinjections).

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, are still 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 context. There is no strong evidence supporting the use of cervical facet injection for the treatment of neck pain. There is no documentation that the cervical facets are the main pain generator. There is no documentation of formal rehabilitation plan that will be used in addition to facet injections. Furthermore, there is no documentation of rational behind the request for cervical facet block and whether this is used for diagnostic and therapeutic purpose. Therefore, Facet Injection at C2-3 is not medically necessary.

Cervical Epidural Steroid Injection at Left C6-7: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 174, 175, 181,Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs), Criteria for use of

Epidural. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter: Criteria for the use of Epidural Injections

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, 309.

Decision rationale: According to MTUS guidelines, cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. Epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit, however there is no signficant long term benefit or reduction for the need of surgery. Furthermore, the patient file does not document that the patient is candidate for surgery. Although, there is clinical and electrodiagnostic evidence supporting the diagnosis cervical radiculopathy, there is no clear documentation of failure of conservative therapies. MTUS guidelines does not recommend epidural injections for neck pain without radiculopathy (309) or for radiculopathy that did respond to conservative therapies . Therefore, the request for Cervical Epidural Steroid Injection at Left C6-7 is not medically necessary.