

Case Number:	CM13-0049371		
Date Assigned:	12/27/2013	Date of Injury:	06/01/1998
Decision Date:	02/25/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	11/07/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Emergency Medicine and is licensed to practice in New York and Tennessee. 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 physician 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 47-year-old female with complaints of continuing upper and mid-back pain. Date of injury was June 1, 1998. Mechanism of injury was possible due to lifting patients as a paramedic over a 6-year period. The patient had undergone spinal fusion surgery at T6 and T7 in 2002. On October 7, 2013, the patient was experiencing pain in her low back, mid-back, upper back, and right chest. Physical examination showed no motor or sensory deficits. The patient did have pain on cervical extension and mid-thoracic discomfort when lifting her shoulders against resistance. MRI of the thoracic spine done on September 12, 2013 showed fusion at T6-7 with suggestion of flattening of the thoracic cord at T5. Diagnosis was postlaminectomy syndrome of thoracic origin. Treatments which had helped in the past included medications, TENS unit, home exercise, hydrotherapy. Past treatments that had not helped included acupuncture, biofeedback, counseling, and psychotherapy. Request for authorization for thoracic T6, 7, 8 bilateral medial branch block, and psychotherapy for evaluation for long term opioid use, possible candidate for spinal cord stimulation were submitted on October 16, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral medial branch blocks T6, T7, T8: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back: Thoracic and Lumbar, Facet joint Mediated Blocks

Decision rationale: When medial branch blocks are performed, it is recommended that no more than one set of medial branch diagnostic blocks be performed prior to facet neurotomy, if neurotomy is chosen as an option for treatment. Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Criteria for the use of diagnostic blocks for facet "mediated" pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of $\geq 70\%$. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a "sedative" during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. In this case the patient had had spinal fusion at T6 and T7 in 2002. Criteria for medical branch blocks/diagnostic facet blocks should not be performed if the patient has had previous fusion procedure at the planned injection level. Criteria are not met for performing this procedure.

psych evaluation with pain psychologist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guideline Page(s): 101-102.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that psychological treatment is recommended for appropriately identified patients during treatment for chronic pain. The guidelines also state that psychological intervention includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders. There is no recommendation for psychological evaluation for long term opioid use. Screening for misuse and addiction is recommended prior to opioid use, but this does not require the services

of a psychologist. There is no documentation that the patient was suffering from depression/ anxiety or other psychologic disorder. Medical necessity is not established.