

Case Number:	CM14-0123442		
Date Assigned:	08/08/2014	Date of Injury:	12/14/1990
Decision Date:	09/17/2014	UR Denial Date:	07/10/2014
Priority:	Standard	Application Received:	08/04/2014

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 Physical Medicine, has a subspecialty in Pain Management and is licensed to practice in California and Washington. 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 injured worker is a 68-year-old male who reported an injury on 12/14/1990. The mechanism of injury was not provided within the medical records submitted for review. The injured worker's diagnoses included spinal stenosis, cervical spondylosis, opioid type dependence, unspecified thoracic/lumbosacral neuritis or radiculitis, lumbosacral spondylosis, and lumbalgia. Previous treatments included a selective nerve root block at L5 on 10/01/2013. Diagnostic studies were not provided within the medical records submitted for review. Surgical history was not provided within the medical records submitted for review. As per the clinical note dated 06/11/2014, the injured worker complained of increased cervical and lumbar pain, and would like to consider injection therapy. The injured worker reported cervical pain was worse with flexion, extension, and rotation. The injured worker reported the lumbar pain was also worse with standing and there was radicular pain. The physical examination noted the injured worker was positive for neck pain, muscle pain/spasm, and lumbar pain. The documentation noted the injured worker was tender to palpation over the cervical spine and thoracic paraspinous area and had decreased range of motion in all planes of the lower back. Medications included tramadol 50mg 3 times a day and a Lidoderm patch. The provider requested a right and left side facet with fluoroscopy and mac at C4-5 and C5-6. The rationale for the requested treatment plan was not provided within the medical records submitted for review. The Request for Authorization form was not provided within the medical records submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right and Left side facet with fluoroscopy and mac at C4/5, C5/6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Facet Joint Diagnostic Blocks.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 8 Neck and Upper Back Complaints, page 173 and on the Non-MTUS Official Disability Guidelines (ODG) Neck and Upper Back, Facet Joint Diagnostic Blocks. The Expert Reviewer's decision rationale: The injured worker has a history of radicular pain in the cervical and lumbar region. The California MTUS/ACOEM Guidelines state that "invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints, or corticosteroids, Lidocaine, or opioids in the epidural space) have no proven benefit treating acute neck and upper back symptoms." The Official Disability Guidelines recommend facet joint diagnostic blocks prior to facet neurotomy. The guidelines state that "diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. The criteria for the use of diagnostic blocks for facet nerve pain include limited to injured workers with cervical pain that is non-radicular and at no more than 2 levels bilaterally, and there should be documentation of failure of conservative treatment (including home exercise, physical therapy, and NSAIDs) prior to the procedure for at least 4 to 6 weeks." The documentation provided noted the injured worker has a history of neck pain associated with radicular symptoms. However, the documentation provided failed to indicate any significant objective functional deficits to warrant the procedure. The documentation provided noted the patient reported that Tramadol helped with the pain; however, the documentation failed to indicate improved functional capacity with medications. There is a lack of documentation that the injured worker has recently participated in physical therapy and failed to improve functional capacity. Overall, there is a lack of documentation to indicate failure of conservative treatment to include medications and physical methods to provide symptomatic relief and improve functional capacity to warrant the procedure. Additionally, the guidelines do not support facet injections for cervical pain with radicular symptoms. Based on the above, the decision for right left side facet with fluoroscopy and mac at C4-5, C5-6 is not medically necessary.