

Case Number:	CM14-0028248		
Date Assigned:	06/13/2014	Date of Injury:	02/03/2003
Decision Date:	08/21/2014	UR Denial Date:	02/28/2014
Priority:	Standard	Application Received:	03/05/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 62-year-old female with date of injury of 02/03/2003. The listed diagnoses per [REDACTED] dated 01/21/2014 are: 1. Chest pain. 2. History of mitral valve prolapse. 3. Claudication. 4. Anxiety. 5. Arthritis of the left shoulder. 6. Tremor. 7. Gastroesophageal reflux disease. 8. Degenerative disk disease. According to the progress report by [REDACTED] dated 02/17/2014, the patient complains of cervical pain. She rates her pain 6/10. The patient is experiencing back stiffness. The patient states that turning her neck to the left and the right worsens her condition. The patient describes the pain as aching, deep, inconsistent, intermittent, pressure, radiating, shifting, stabbing, tender, throbbing, pinching, weak, and shooting down the hip. The objective findings show head is normocephalic, atraumatic without any gross head or neck masses. Inspection of the bones, joints, and muscles is unremarkable. There is tenderness at the Acromioclavicular (AC) joints, mild on the left. Deep tendon reflexes are normal. Neck exam reveals no pain to palpation over the C2-C3, C3-C4, C4-C5 facet capsules on the left. Spurling's maneuver is positive on the left. The utilization review denied the request on 02/28/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

DORSAL RAMI DIAGNOSTIC BLOCK, CERVICAL SPINE RIGHT C4-7 QTY:1.00:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 174-175.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar spine: Recommend diagnostic blocks, as well as indicators below. Diagnostic blocks are required, with controlled comparative blocks suggested as uncontrolled blocks are associated with high false-positive rates (17% to 47% in the lumbar spine). (Bogduk, 2005) The most commonly involved lumbar joints are L4-5 and L5-S1. (Dreyfus, 2003) In the lumbar region, the majority of patients have involvement in no more than two levels. (Manchikanti, 2004) The cause of this condition is largely unknown, but suggested etiologies have included microtrauma, degenerative changes, and inflammation of the synovial capsule. There are no findings on history, physical or imaging studies that consistently aid in making this diagnosis. In 1998, Revel et al. suggested that the presence of the following were helpful in identifying patients with this condition: (1) age > 65; (2) pain relieved when supine; (3) no increase in pain with coughing, hyperextension, forward flexion, rising from flexion or extension/rotation. (Revel, 1998) This is in contrast to researchers who had previously suggested that pain secondary to the lumbar facet was increased with extension and rotation. Other authors have suggested that pain secondary to the lumbar facet is characterized by groin, buttock and/or thigh pain as well as paraspinous muscle tenderness. The condition has been described as both acute and chronic. (Resnick, 2005) See also Facet joint diagnostic blocks (injections). Suggested indicators of pain related to facet joint pathology (acknowledging the contradictory findings in current research): 1) Tenderness to palpation in the paravertebral areas (over the facet region); 2) Decreased range of motion of the spine, with frequent evidence of pain on lateral bending; extension and forward flexion while standing; 3) Improvement of pain when recumbent; 4) A normal sensory examination; 5) Absence of radicular findings, although pain may radiate below the knee; 6) Normal straight leg raising unless there is hypertrophy encroaching on the neural foramen. 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 70%. The pain response should be approximately 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.

Decision rationale: This patient presents with cervical pain. The treater is requesting a dorsal rami diagnostic block at the right C4-C7. The ACOEM Guidelines discuss dorsal medial branch blocks and RF ablations on page 78 footnote. For a more thorough discussion of facet joint diagnostic evaluations, the ODG Guideline is used. The ODG Guidelines support facet diagnostic evaluations for patients presenting with paravertebral tenderness with non-radicular symptoms. No more than 2 facet joint levels bilaterally are to be studied. In this case, the patient does not present with paravertebral tenderness in the cervical spine and the requested C4-C7 nerve levels would cover 3 facet joints which exceeds ODG's recommendation. The request is not medically necessary.

PRESTIQ 50MG QTY:70.00: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 15.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Depressants Page(s): 13-15.

Decision rationale: This patient presents with cervical pain. The treater is requesting Pristiq 50 mg #70. The MTUS Guidelines page 13 to 15 on antidepressants for chronic pain states that it is recommended as a first-line option for neuropathic pain and as a possibility for non-neuropathic pain. Tricyclics are generally considered the first-line agents unless they are ineffective, poorly tolerated, or contraindicated. Assessment and treatment efficacy should include not only pain outcomes but also an evaluation of function, changes in use of other analgesics, and sleep quality and psychological assessment. The record show that the patient has been on Pristiq since 09/2013. The treater documents medication efficacy stating and has noted benefit with the use of medications which increased the injured worker's global functioning. In this case, the treater documents medication efficacy and continued use of Pristiq is reasonable. The request is medically necessary.