

Case Number:	CM15-0048685		
Date Assigned:	03/20/2015	Date of Injury:	08/13/2009
Decision Date:	05/01/2015	UR Denial Date:	02/26/2015
Priority:	Standard	Application Received:	03/16/2015

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, Michigan, 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 is a 60-year-old male, who sustained a work/ industrial injury on 8/13/09. He has reported initial symptoms of neck and back pain. The injured worker was diagnosed as having chronic lumbosacral sprain lumbar discogenic disease and cervicgia. Treatments to date included, medication, diagnostics, psychiatric care, physical therapy, chiropractic care, surgery (C5-7 (2012). Magnetic Resonance Imaging (MRI) on 3/4/15 reported mild to moderate disc desiccation signal increasing from L3-4 throughout L5-S1 without disc narrowing, low grade degenerative signal anterior superior corner of L3-4 with mild left facet joint disease and small lateral disc osteophyte complexes at L3-4 and lateral recess stenosis without neural compression. L4-5 low grade left facet arthrosis, broad based disc bulge with a far left lateral annular tear, moderate left lateral recess stenosis with effacement of the epidural fat around the root. L5-S1 low-grade facet arthrosis, and small disc bulge. Currently, the injured worker complains of constant neck and back pain. There was underlying depression and insomnia. The treating physician's report (PR-2) from 1/15/15 indicated there was facet tenderness on the lumbar spine, positive straight leg raise (SLR) on the right, pain reproduced with bilateral facet loading of the lumbar spine, decreased range of motion, muscle strength of 5/5, patellar reflexes 2/4 on the right and left. Medications included Soma, Norco, and dyna cream. Treatment plan included Medial Branch Blocks Bilateral C2, C3, C4, and C5 under fluoroscopic guidance and with sedation and Acupuncture x 12 visits to neck.

IMR ISSUES, DECISIONS AND RATIONALES

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

MEDIAL BRANCH BLOCKS BILATERAL C2, C3, C4, C5 UNDER FLUOROSCOPIC GUIDANCE AND WITH SEDATION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

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. The ODG guidelines did not support facet injection for cervical pain in this clinical context. There is no documentation of facet mediated pain or that facets are the main pain generator. There is no documentation of failure of conservative therapies in this patient. No more that 2 level facet injections at one session are authorized by the guidelines. Therefore, the request for MEDIAL BRANCH BLOCKS BILATERAL C2, C3, C4, C5 UNDER FLUOROSCOPIC GUIDANCE AND WITH SEDATION is not medically necessary.

ACUPUNCTURE X 12 VISITS TO NECK: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to MTUS guidelines, Acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Furthermore and according to MTUS guidelines, Acupuncture with electrical stimulation is the use of electrical current (microamperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites. The patient developed chronic neck pain. There is no controlled studies supporting the efficacy of acupuncture for chronic neck pain. MTUS guidelines do not recommend acupuncture for chronic neck pain. More sessions could be considered when functional and objective improvement are documented. Therefore, the request for 12 acupuncture visits to neck is not medically necessary.