

Case Number:	CM14-0087052		
Date Assigned:	07/25/2014	Date of Injury:	05/07/2013
Decision Date:	09/24/2014	UR Denial Date:	06/02/2014
Priority:	Standard	Application Received:	06/11/2014

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 Internal Medicine and is licensed to practice in Maryland. 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 employee was a 62-year-old male who sustained an injury to his upper back while doing repetitive tasks. The date of injury was 5/7/13. The initial injury report from 12/21/13 was reviewed. His primary complaint was pain in the right hemithorax which was radiating around from the back to the front at the level of about T8 or so. His pain was worse with movements and he had trouble with lifting anything significant. His treatment in the past included oral medications, Norco, muscle relaxants, An MRI of the thoracic spine completed on 10/24/13 revealed multilevel degenerative changes with narrowing of the spinal canal and neuroforamina. Chronic mild anterior wedge compression fracture of the T12 vertebral body was also noted. Thoracic spine x-ray from 12/11/13 showed dextroscoliosis and mild retrolisthesis. His visit notes from 2/19/14 was reviewed. His subjective complaints at the time was mid back pain. His medications at the time were Flexeril and Norco. Pertinent examination findings included thoracic kyphosis and he got symptoms of thoracic radiculopathy with Kemp maneuver of the T-spine. His diagnoses during that visit were thoracic disc degeneration and kyphosis of the thoracic spine/scoliosis of the thoracic spine. He was referred for Physical therapy and pain management. The initial notes from Pain Management was from 03/14/14. His complaints were pain in upper back and mid back with some radicular bilateral chest pain. His examination was significant for spasm and tenderness on the left paravertebral muscles. He had positive thoracic and lumbar facet loading bilaterally. On sensory examination he was noted to have decreased sensation to pinprick over chest wall and in the thoracic region T6-T9 on both the sides. His urine drug screen was negative. His diagnoses during this visit was thoracic facet syndrome, thoracic radiculopathy and thoracic compression fracture at the T12 level. His treatment plan included continuation of Norco, Flexeril and Motrin, request for medial nerve branch block diagnostic, Lyrica and physical therapy. He was seen by the PMR provider on 4/2/14. He was

having dizziness from the Lyrica and was having less shooting thoracic pain. Pertinent examination findings included similar back exam without significant change and better active range of motion of shoulders. Diagnoses included thoracic disc degeneration and kyphosis of the thoracic spine/scoliosis of the thoracic spine. Plan of care included an MRI of the thoracic spine and diagnostic medial branch block. An MRI of thoracic spine on 04/28/14 was significant for multilevel minimal annular bulges without herniated disc or spinal stenosis. The visit notes from Pain management provider was reviewed from 06/06/14. he had mid back pain 5/10 without medications and 2/10 with medications. He denied any more radicular symptoms across his chest. He wished to discontinue Lyrica. His medications were Lyrica, Lidoderm patch, Norco, Vicodin, Flexeril and Cymbalta. Examination findings were similar to his previous visit including positive thoracic facet loading and decreased sensation over chest wall in T6-T9 regions. His diagnoses were thoracic facet syndrome, thoracic radiculopathy and thoracic compression fracture at T12. He was noted to not have any more radiculopathy symptoms and hence an updated request was sent for diagnostic medial nerve branch block given failure to improve with conservative management and MRI findings consistent with facet arthropathy. His primary treating provider's note from 06/10/14 reports that the diagnostic medial nerve branch block was requested to treat his axial symptoms and not his radicular symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial branch nerve blocks bilateral T6-T7 Qty: 1.00: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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 lumbar and thoracic, Facet joint pain and facet joint diagnostic blocks.

Decision rationale: The employee was being treated for thoracic facet syndrome, thoracic radiculopathy and chronic compression fracture of T12. His prior treatment included physical therapy, Norco, Flexeril and Motrin. His MRI showed multi level disc bulge and canal stenosis. The pain management consultant requested diagnostic medial branch blocks at T6-T7 and T7-T8. According to Official disability guidelines, facet joint pain is suggested by the following findings: tenderness to palpation in the paravertebral region, a normal sensory examination, absence of radicular findings and normal straight leg raising exam. The guidelines further report that radiculopathy may be present in the presence of osteophytes, synovial cysts or facet hypertrophy. Guidelines enumerate criteria for diagnostic medial branch blocks: limited to patients with low back pain that is non-radicular; no more than 2 levels at a time; failure to improve with conservative treatment and not in patients who have or who are having surgery. The employee had thoracic back pain with positive facet loading and decreased sensation over T6-T9 regions. In addition to having axial pain, he also had radicular symptoms with positive Kemp's test during his initial visit. The radicular symptoms improved with Lyrica, but he continued to have axial pain. He has tried Physical therapy, analgesics and muscle relaxants. He was continuing to work with work modification. Given the failure to improve with conservative

measures, improvement of radicular pain on Lyrica, persistence of axial pain and to prevent further escalation of opiates, medial branch diagnostic block was requested. Initial denial states that presence of radicular pain as the reason for denial of the request. But, he has resolution of the radicular component of pain and is being taken off of Lyrica. Hence the request for diagnostic thoracic medial branch block bilaterally at T6-T7 and T7-T8 is medically necessary and appropriate.

Medial branch nerve blocks bilateral T7-T8 Qty: 1.00: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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 lumbar and thoracic, Facet joint pain and facet joint diagnostic blocks.

Decision rationale: The employee was being treated for thoracic facet syndrome, thoracic radiculopathy and chronic compression fracture of T12. His prior treatment included physical therapy, Norco, Flexeril and Motrin. His MRI showed multi level disc bulge and canal stenosis. The pain management consultant requested diagnostic medial branch blocks at T6-T7 and T7-T8. According to Official disability guidelines, facet joint pain is suggested by the following findings: tenderness to palpation in the paravertebral region, a normal sensory examination, absence of radicular findings and normal straight leg raising exam. The guidelines further report that radiculopathy may be present in the presence of osteophytes, synovial cysts or facet hypertrophy. Guidelines enumerate criteria for diagnostic medial branch blocks: limited to patients with low back pain that is non-radicular; no more than 2 levels at a time; failure to improve with conservative treatment and not in patients who have or who are having surgery. The employee had thoracic back pain with positive facet loading and decreased sensation over T6-T9 regions. In addition to having axial pain, he also had radicular symptoms with positive Kemp's test during his initial visit. The radicular symptoms improved with Lyrica, but he continued to have axial pain. He has tried Physical therapy, analgesics and muscle relaxants. He was continuing to work with work modification. Given the failure to improve with conservative measures, improvement of radicular pain on Lyrica, persistence of axial pain and to prevent further escalation of opiates, medial branch diagnostic block was requested. Initial denial states that presence of radicular pain as the reason for denial of the request. But, he has resolution of the radicular component of pain and is being taken off of Lyrica. Hence the request for diagnostic thoracic medial branch block bilaterally at T6-T7 and T7-T8 is medically necessary and appropriate.