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| Case Number: | CM15-0118985 | | |
| Date Assigned: | 06/29/2015 | Date of Injury: | 11/27/2012 |
| Decision Date: | 07/28/2015 | UR Denial Date: | 06/04/2015 |
| Priority: | Standard | Application Received: | 06/19/2015 |

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 44 year old male who sustained an industrial injury on 11/27/2012. The injured worker was diagnosed with cervicgia, lumbago and osteoarthritis left knee. The injured worker is status post anterior cervical discectomy and fusion on April 17, 2014. Treatment to date has included diagnostic testing, surgery, physical therapy, epidural steroid injection, lumbar radiofrequency ablation and medications. According to the primary treating physician's progress report on May 27, 2015, the injured worker continues to experience neck and left upper extremity pain and difficulty sleeping. The injured worker rates his pain level at 6/10. The injured worker also reports left sided back pain and left knee pain. Examination of the cervical spine demonstrated positive facet loading at left C5-C6 and C6-C7. The lumbar spine was positive for facet loading test on the left side. Current medications are listed as Norco 10/325mg, Celebrex and Cymbalta. Treatment plan consists of radiofrequency ablation to left L3 and L4 and the current request for medial branch block at left C5-C6 and left C6-C7 and transcutaneous electrical nerve stimulator (TEN's) unit purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial branch block at left C5-C6 and left C6-C7: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 3 Initial Approaches to Treatment Page(s): 48, 174, 181. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back, Facet joint pain, signs & symptoms.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Neck and Upper Back Complaints, page 174. Decision based on Non-MTUS Citation ODG, Neck & Upper Back, Facet joint diagnostic blocks, pages 601-602.

Decision rationale: Per ODG, facet blocks are not recommended except as a diagnostic tool as there is minimal evidence for treatment and current evidence is conflicting as to this procedure. At this time no more than one therapeutic intra-articular block is suggested and with positive significant relief for a duration of at least 6 weeks, the recommendation is to proceed with subsequent neurotomy. Facet blocks are not recommended without defined imaging or clinical correlation, not identified here. There is no report of acute flare-up or change for this chronic injury. Additionally, facet injections/blocks are not recommended in patient who may exhibit radicular symptoms with nerve impingement s/p previous cervical epidural steroid injections with noted relief or should the blocks be performed over 2 joint levels concurrently (C5, C6, C7) and at any previous surgical sites. Records have not specified failed conservative treatment trials as an approach towards a functional restoration process for this chronic injury. Submitted reports have not demonstrated support outside guidelines criteria. The Medial branch block at left C5-C6 and left C6-C7 is not medically necessary and appropriate.

Durable medical equipment: TENS unit purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain, pages 114-117.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, the patient has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive physical therapy, TENS, activity modifications, yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, nor is there any documented short-term or long-term goals of treatment with the TENS unit purchase. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the treatment already rendered since at least 2013. The Durable medical equipment: TENS unit purchase is not medically necessary and appropriate.

