

Case Number:	CM15-0122591		
Date Assigned:	07/06/2015	Date of Injury:	04/30/2014
Decision Date:	07/31/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	06/24/2015

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: Arizona, California
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 43-year-old female sustained an industrial injury to the neck, low back and shoulder on 4/30/14. Previous treatment included magnetic resonance imaging, physical therapy, transcutaneous electrical nerve stimulator unit and medications. Magnetic resonance imaging cervical spine showed a previous cervical fusion, a large C6-7 herniated nucleus pulposus with severe cord compression and significant congenital stenosis throughout the cervical spine. Magnetic resonance imaging lumbar spine (3/12/15) showed severe facet arthropathy at L4-5 with joint fluid and L5-S1 joint fluid hyperintensity. In a visit note dated 3/4/15, the injured worker complained of severe neck pain with radiation down to the shoulders and arms as well as low back pain. The physician noted that the injured worker had been having trouble with severe pain and difficulty with strength in the hands and worsening problems with walking due to pain. Current diagnoses included cervicgia, lumbago, cervical spine stenosis and displacement of cervical intervertebral disc without myelopathy. On 4/14/15, a request for authorization was submitted for cervical disc fusion and L4-5 and L5-S1 facet block and rhizotomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient Facet block and Rhizotomy L4, L5, and S1 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 (ODG)- Treatment in Workers' Comp 2012 on the web (www. odgtreatment. com). Work Loss Data Institute (www. worklossdata. com) (updated 02/14/2012).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- low back pain and MBB- page 36 Facet neurotomy and pg 40.

Decision rationale: According to the guidelines, 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 last at least 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 hours afterward. 7. Opioids should not be given as a sedative during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. Criteria for use of facet joint radiofrequency neurotomy: (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections). (2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period. (3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function. (4) No more than two joint levels are to be performed at one time. (5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks. (6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. In this case, the claimant has persistent back pain and facet tenderness. There is no evidence of radiculopathy. Neurosurgery had requested the procedure. The request for a facet block and rhizotomy and medically necessary to improve function and pain.