

Case Number:	CM15-0096249		
Date Assigned:	05/27/2015	Date of Injury:	11/30/2006
Decision Date:	07/07/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	05/19/2015

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 was a 60-year-old female, who sustained an industrial injury, November 30, 2006. The injured worker previously received the following treatments cervical spine MRI central disc protrusion at C2-C3 without compromise of the neural elements, Dilaudid, Codeine, Flexeril, Lyrica and Diclofenac. The injured worker was diagnosed with cervical fusion of C3-C7, left total knee, postlaminectomy syndrome of the cervical region, and T1 thoracic spondylosis without myelopathy, cervical spondylosis without myelopathy and cervical disc displacement without myelopathy. According to progress note of April 17, 2015, the injured workers chief complaint was pain in the upper back and neck. The injured worker was having an exacerbation of burning sensation since stopping Lyrica. The Diclofenac was ineffective and caused itching. The pain was severe and disabling. The chronic neck pain was from accumulative trauma. The pain was in the lower neck and upper spine. The pain was described as constant 6-7 out of 10. Movement, relief with rest with radiation of pain, aggravated the pain. The pain had overall limits with activities of daily functions and decreased quality of life. The physical exam noted upright with normal posture, ambulates without assistance and gait was normal. The examination of the neck and upper back noted tenderness of the upper thoracic and low-neck paraspinals. There was decreased active range of motion and passive range of motion. The Spurling's test was positive bilaterally. The treatment plan included physical therapy for the cervical spine, bilateral C8 medial branch block, bilateral T1 medial branch block and bilateral T2 medial branch block.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, Cervical spine, 24 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: The patient was injured on 11/30/06 and presents with upper back pain and neck pain. The request is for PHYSICAL THERAPY FOR THE CERVICAL SPINE 24 SESSIONS. There is no RFA provided and the patient's work status is not provided. Review of the reports provided does not indicate if the patient had any prior physical therapy. MTUS pages 98 and 99 have the following: Physical medicine: Recommended as an indicated below. Allow for fading of treatments frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. MTUS Guidelines pages 98 and 99 state that for myalgia, myositis, 9 to 10 visits are recommended over 8 weeks, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits are recommended. The patient is diagnosed with cervical fusion of C3-C7, left total knee, postlaminectomy syndrome of the cervical region, T1 thoracic spondylosis without myelopathy, cervical spondylosis without myelopathy, and cervical disc displacement without myelopathy. The 04/17/15 report states that the "patient will be referred to PT for Cer Spine ROM/stretching, strengthening, soft tissue mobility, myofascial release, joint mobilization, modalities including US, ice/heat, and iontophoresis." There is no indication of any recent surgery the patient may have had, and there is no discussion regarding why the patient is unable to establish a home exercise program to manage his pain. Given that the patient has not had any recent therapy, a course of therapy may be reasonable to help with chronic pain and the patient's decline in function. However, the requested 24 sessions of therapy exceeds what is allowed by MTUS guidelines. The requested 24 sessions of therapy IS NOT medically necessary.

Bilateral Medial Branch Block, Cervical Spine C8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lumbar sympathetic block Page(s): 57. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Facet joint diagnostic blocks (injections).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper Back Chapter, under Facet joint diagnostic blocks.

Decision rationale: The patient was injured on 11/30/06 and presents with upper back pain and neck pain. The request is for BILATERAL MEDIAL BRANCH BLOCK CERVICAL SPINE C8. There is no RFA provided and the patient's work status is not provided. MTUS/ACOEM Neck Complaints, Chapter 8, page 174-175, under Initial Care states: For Invasive, techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet

joints, or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injections may help patients presenting in the transitional phase between acute and chronic pain. ODG-TWC, Neck and Upper Back Chapter, under Facet joint diagnostic blocks states: Recommended prior to facet neurotomy, a procedure that is considered "under study." Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block, MBB. Criteria for the use of diagnostic blocks for facet nerve 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 cervical 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 joint levels are injected in one session. For facet joint pain signs and symptoms, the ODG guidelines state that physical examination findings are generally described as: "1. axial pain, either with no radiation or severity past the shoulders; 2. tenderness to palpation in the paravertebral areas, over the facet region; 3. decreased range of motion, particularly with extension and rotation; and 4. absence of radicular and/or neurologic findings." The patient is diagnosed with cervical fusion of C3-C7, left total knee, postlaminectomy syndrome of the cervical region, T1 thoracic spondylosis without myelopathy, cervical spondylosis without myelopathy, and cervical disc displacement without myelopathy. There is tenderness of the upper thoracic and lower neck paraspinals and a decreased range of motion. Regarding the requested diagnostic cervical medial branch block, the patient does not meet guideline criteria. There is no evidence that this patient has not had any medial branch blocks to date, nor is she anticipating surgery. The requested number of levels is appropriate, and there is documentation of a failure of conservative therapies to date. However, the 04/17/15 report states that the "patient's pain is lower neck and upper spine, constant, 6-7/10, aggravated with movement, relief with rest, radiation of pain." While neurological function in the bilateral upper extremities is otherwise intact, the presence of radicular symptoms precludes a medial branch block at the requested levels. Guidelines require a lack of radicular pain in the upper extremities prior to a cervical medial branch block. Given the information provided, such a block cannot be substantiated. Therefore, the request IS NOT medically necessary.

Bilateral Medial Branch Block, Thoracic spine, T1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lumbar sympathetic block Page(s): 57. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Facet joint diagnostic blocks (injections).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Facet joint diagnostic blocks (injections).

Decision rationale: The patient was injured on 11/30/06 and presents with upper back pain and neck pain. The request is for BILATERAL MEDIAL BRANCH BLOCK THORACIC SPINE

T1. There is no RFA provided and the patient's work status is not provided. ODG Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Facet joint diagnostic blocks (injections) Section states: "For Facet joint diagnostic blocks for both facet joint and Dorsal Median Branches: Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally." "... there should be no evidence of radicular pain, spinal stenosis, or previous fusion," and "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 medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive)." The patient is diagnosed with cervical fusion of C3-C7, left total knee, postlaminectomy syndrome of the cervical region, T1 thoracic spondylosis without myelopathy, cervical spondylosis without myelopathy, and cervical disc displacement without myelopathy. There is tenderness of the upper thoracic and lower neck paraspinals and a decreased range of motion. Regarding the requested diagnostic cervical medial branch block, the patient does not meet guideline criteria. There is no evidence that this patient has not had any medial branch blocks to date, nor is she anticipating surgery. The requested number of levels is appropriate, and there is documentation of a failure of conservative therapies to date. However, the 04/17/15 report states that the "patient's pain is lower neck and upper spine, constant, 6-7/10, aggravated with movement, relief with rest, radiation of pain." While neurological function in the bilateral upper extremities is otherwise intact, the presence of radicular symptoms precludes a medial branch block at the requested levels. Guidelines require a lack of radicular pain in the upper extremities prior to a cervical medial branch block. Given the information provided, such a block cannot be substantiated. Therefore, the request IS NOT medically necessary.

Bilateral Medial Branch Block, Thoracic spine, T2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lumbar sympathetic block Page(s): 57. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Facet joint diagnostic blocks (injections).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Facet joint diagnostic blocks (injections).

Decision rationale: The patient was injured on 11/30/06 and presents with upper back pain and neck pain. The request is for BILATERAL MEDIAL BRANCH BLOCK THORACIC SPINE T2. There is no RFA provided and the patient's work status is not provided. ODG Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Facet joint diagnostic blocks (injections) Section states: "For Facet joint diagnostic blocks for both facet joint and Dorsal Median Branches: Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally." "... there should be no evidence of radicular pain, spinal stenosis, or previous fusion," and "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 medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive)." The patient is diagnosed with cervical fusion of C3-C7, left total knee, postlaminectomy syndrome of the cervical region, T1 thoracic spondylosis without myelopathy, cervical spondylosis without myelopathy, and cervical disc displacement without myelopathy. There is tenderness of

the upper thoracic and lower neck paraspinals and a decreased range of motion. Regarding the requested diagnostic cervical medial branch block, the patient does not meet guideline criteria. There is no evidence that this patient has not had any medial branch blocks to date, nor is she anticipating surgery. The requested number of levels is appropriate, and there is documentation of a failure of conservative therapies to date. However, the 04/17/15 report states that the "patient's pain is lower neck and upper spine, constant, 6-7/10, aggravated with movement, relief with rest, radiation of pain." While neurological function in the bilateral upper extremities is otherwise intact, the presence of radicular symptoms precludes a medial branch block at the requested levels. Guidelines require a lack of radicular pain in the upper extremities prior to a cervical medial branch block. Given the information provided, such a block cannot be substantiated. Therefore, the request IS NOT medically necessary.