

Case Number:	CM13-0016942		
Date Assigned:	12/11/2013	Date of Injury:	12/19/1993
Decision Date:	01/27/2014	UR Denial Date:	08/07/2013
Priority:	Standard	Application Received:	08/27/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Emergency Medicine, and is licensed to practice in New York and Tennessee. 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 physician 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 patient is a 56-year-old-male who continued to complain of lower back pain with radiation to the left leg and foot. Date of injury was 12/19/93. Injury involved lifting beverage containers weighing 80 pounds and pushing carts. Diagnosis was lumbar disc degeneration and lumbosacral spondylosis without myelopathy. The patient was treated with physical therapy and medications. MRI done on March 20, 2013 was read as showing mild spondylosis with mild canal narrowing at L4-5, mild facet degenerative changes, mild foraminal narrowing at right L4-5 and bilateral L5-S1, and moderate right and mild left facet degenerative changes. Physical exam was documented as well-developed and well-nourished in no apparent distress. There is no documentation of motor or sensory deficits. The patient underwent diagnostic lumbar medial branch block at L4-5 and L5-S1 facet joints on the left on July 22, 2013. He experienced relief for 24 hours. Request for authorization for confirmatory repeat lumbar medial branch block under fluoroscopy with conscious sedation at L4-5 and L5-S1 was submitted in August 7, 2013

IMR ISSUES, DECISIONS AND RATIONALES

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

Confirmatory repeat lumbar medial branch block under fluoroscopy with conscious sedation at L4-5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 300.

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: Thoracic and Lumbar, Facet joint Mediated Blocks

Decision rationale: Facet joint diagnostic blocks are recommended in only one set of medial branch diagnostic blocks prior to facet neurology, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). Diagnostic blocks may be 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). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. Etiology of false positive blocks is: Placebo response, use of sedation, liberal use of local anesthetic, and spread of injectate to other pain generators. The concomitant use of sedative during the block can also interfere with an accurate diagnosis. 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 $\geq 70\%$. 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. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusi