

Case Number:	CM13-0052902		
Date Assigned:	12/30/2013	Date of Injury:	06/10/2006
Decision Date:	05/21/2014	UR Denial Date:	11/06/2013
Priority:	Standard	Application Received:	11/18/2013

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 Neurology, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in California. 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 patient has sustained a work-related injury on June 10, 2006. Subsequently, she developed chronic back pain. According to note date on October 25, 2013, the patient underwent two previous nerve blocks without benefit. The patient's physical examination demonstrated numbness and tingling in the right lower extremity with reduced range of motion and tenderness in the lumbosacral area and over the lower lumbar facet joints. The patient has positive lumbar facet maneuvers. Patrick's test was positive. Straight leg raise was positive at 30°. Her MRI (magnetic resonance imaging) of the lumbar spine performed on May 20, 2013 demonstrated multilevel degenerative spondylosis with severe neural foraminal stenosis on the right L3-L4 and L4-L5 and severe left foraminal stenosis at L5-S1. The patient was treated with methadone morphine, Cymbalta, Ultram, Lyrica, fentanyl patch, and ibuprofen. The provider requested authorization for lumbar facet joint injection with medial branch block at L3-4 and L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

OUTPATIENT LUMBAR FACET JOINT INJECTION AND MEDICAL BRANCH BLOCK AT L3-4 AND L5-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): pg. 46,. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Facet joint intra-articular injections (therapeutic blocks) (http://worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#Facetjointinjections)..

Decision rationale: According to the MTUS guidelines, invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain. According to Official Disability Guidelines (ODG) facets injection are under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial. Furthermore and according to ODG guidelines, the criteria for use of therapeutic intra-articular and medial branch blocks are as follows: 1). No more than one therapeutic intra-articular block is recommended. 2). There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3). 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 a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 4). No more than 2 joint levels may be blocked at any one time. 5). There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. The ODG guidelines did not support facet injection for lumbar pain in this clinical context. In this case, there is no clear evidence or documentation that lumbar facets are the main pain generator. Therefore lumbar facet joint injection with medial branch block at L3-4 and L5-S1 is not medically necessary.