

Case Number:	CM14-0104520		
Date Assigned:	07/30/2014	Date of Injury:	09/15/2012
Decision Date:	09/24/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/07/2014

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 Physical Medicine and Rehabilitation, 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 injured worker is a 38-year-old male who reported an injury on 09/15/2012 due to cumulative trauma. Diagnoses were lumbar spine pain, lumbar spine degenerative disc disease, herniated disc, bulge, lumbar spine radiculopathy. Past treatments were physical therapy and 3 epidural steroid injections. Diagnostic studies were an MRI of the lumbar spine on 07/25/2013 that revealed there was no evidence of spinal canal stenosis or neural foraminal narrowing at the following levels: L1-2, L2-3, and L3-4. At the L4-5, there was an annular disc tear with disc desiccation and a disc protrusion. This effaces the ventral thecal sac and causes minimal thecal sac narrowing. The AP diameter of the thecal sac was 1.2 cm. There was mild bilateral neural foraminal narrowing. At the L5-S1, there was no evidence of spinal canal stenosis or neural foraminal narrowing. The injured worker had a physical examination on 05/12/2014 that revealed he had 3 epidural steroid injections in 05/2013, 07/2013, and 09/2013. After his last injection, the injured worker had about 1 month of good relief. The injured worker complained he had low back pain, as well as symptoms that radiated to the calf on the left side. Examination revealed reflexes were 1 to 2+ patellar, trace Achilles bilaterally. Sensation was decreased in the left lateral thigh compared to the right. Straight leg raise was positive with pain into the calf on the left side. Medications were Naproxen, Valium, Norco, Tizanidine HCl. Treatment plan was for repeat epidural steroid injection blocks. The Request for Authorization was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L3 and L4 Medial Branch Block L5 Dorsal Primary Dorsal Block: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 05/12/14).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Facet Joint Diagnostic Blocks.

Decision rationale: The request for right L3 and L4 medial branch block, L5 dorsal primary dorsal block is not medically necessary. The California ACOEM states epidural injections for back pain without radiculopathy are not recommended. Invasive techniques (e.g., local injections, facet joint injections or cortisone and Lidocaine) are of questionable merit. Although epidural steroid injections may afford short term improvement in leg pain and sensory deficits in injured workers 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 injured workers presenting in the transitional phase between acute and chronic pain. The Official Disability Guidelines state for facet joint diagnostic blocks, they are recommended at no more than 1 set of medical branch diagnostic blocks prior to facet neurotomy if neurotomy is chosen as an option for treatment. Criteria for the use of diagnostic blocks for facet mediated pain are 1 set of diagnostic medial branch blocks is required with a response of greater than 70%. The pain response should last at least 2 hours before Lidocaine. It should be limited to injured workers with low back pain that is non-radicular and at no more than 2 levels bilaterally. There should be documentation of failure of conservative treatment prior to the procedure for at least 4 to 6 weeks. No more than 2 facet joint levels are injected in 1 session. 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. Opioids should not be given as a sedative during the procedure. 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. The injured worker should document pain relief with an instrument, such as the VAS, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. Diagnostic facet blocks should not be performed in injured workers in whom a surgical procedure is anticipated. Diagnostic facet blocks should not be performed in injured workers who have had a previous fusion procedure at the planned injection level. On 05/12/2014 examination, the injured worker had a positive straight leg raise with radiation to the calf on the left side. Sensation was decreased in the left lateral thigh. The medical guidelines state there should be non-radicular signs and symptoms. Therefore, the request is not medically necessary.

Left L3 and L4 Medial Branch Block L5 Dorsal Primary Dorsal Block: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 05/12/14).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Facet Joint Diagnostic Blocks.

Decision rationale: The request for left L3 and L4 medial branch block, L5 dorsal primary dorsal block is not medically necessary. The California ACOEM states epidural injections for back pain without radiculopathy are not recommended. Invasive techniques (e.g., local injections, facet joint injections or cortisone and Lidocaine) are of questionable merit. Although epidural steroid injections may afford short term improvement in leg pain and sensory deficits in injured workers 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 injured workers presenting in the transitional phase between acute and chronic pain. The Official Disability Guidelines state for facet joint diagnostic blocks, they are recommended at no more than 1 set of medical branch diagnostic blocks prior to facet neurotomy if neurotomy is chosen as an option for treatment. Criteria for the use of diagnostic blocks for facet mediated pain are 1 set of diagnostic medial branch blocks is required with a response of greater than 70%. The pain response should last at least 2 hours before Lidocaine. It should be limited to injured workers with low back pain that is non-radicular and at no more than 2 levels bilaterally. There should be documentation of failure of conservative treatment prior to the procedure for at least 4 to 6 weeks. No more than 2 facet joint levels are injected in 1 session. 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. Opioids should not be given as a sedative during the procedure. 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. The injured worker should document pain relief with an instrument, such as the VAS, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. Diagnostic facet blocks should not be performed in injured workers in whom a surgical procedure is anticipated. Diagnostic facet blocks should not be performed in injured workers who have had a previous fusion procedure at the planned injection level. On 05/12/2014 examination, the injured worker had a positive straight leg raise with radiation to the calf on the left side. Sensation was decreased in the left lateral thigh. The medical guidelines state there should be non-radicular signs and symptoms. Therefore, the request is not medically necessary.