

Case Number:	CM14-0129430		
Date Assigned:	08/18/2014	Date of Injury:	01/19/2012
Decision Date:	10/02/2014	UR Denial Date:	07/18/2014
Priority:	Standard	Application Received:	08/14/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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:

This case involves a 42 year old woman who sustained a work-related injury on January 19, 2012. According to a follow-up note dated on July 22, 2014, the patient was complaining of ongoing back pain with radiation extending the lower extremities associated with numbness. The patient pain severity was rated 5/10. Her physical examination demonstrated the lumbar tenderness with reduced range of motion, decreased sensation over L5-S1 dermatoma distribution bilaterally and weakness of hip flexion 3 over 5 bilaterally. The patient was diagnosed with the facet arthropathy, lumbar disc degeneration, L5-S1 stenosis, bilateral lumbar radiculopathy and chronic lumbar. The provider requested authorization for facet block L3-S1 and pain management consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Facet Block L3-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. 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 Official Disability Guidelines (ODG) facets injections 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. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti , 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). 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, according to the Official Disability Guidelines (ODG) the criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: no more than one therapeutic intra-articular block is recommended; there should be no evidence of radicular pain, spinal stenosis, or previous fusion; 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); no more than 2 joint levels may be blocked at any one time; 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 Block L3-S1. There is no documentation that the lumbosacral facets are the main pain generator. There is no documentation of formal rehabilitation plan that will be used in addition to facet injections. ODG guidelines does not recommend more than 2 joint levels be blocked at one time. The provider is requesting facet block in more than 2 levels. Furthermore, there is no documentation of rational behind the request for lumbosacral facet block and whether this is used for diagnostic and therapeutic purpose. Therefore, the request for facet block L3-S1 is not medically necessary.

Pain Management Consult: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): Page 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs, early intervention Page(s): 32-33. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) < Guidelines Assessing Red Flags and Indication for Immediate Referral, page(s) 171 >

Decision rationale: According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a pain management evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. In the chronic pain programs, early intervention section of MTUS guidelines stated that recommendation for identification of patients that may benefit from early intervention via a multidisciplinary approach; the patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to

explain symptom severity; the patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis; there is a previous medical history of delayed recovery; the patient is not a candidate where surgery or other treatments would clearly be warranted; inadequate employer support; and loss of employment for greater than 4 weeks. The most discernible indication of at risk status is lost time from work of 4 to 6 weeks. (Mayer 2003). There is documentation that the patient response to pain medications is outside the established norms for recovery from his lumbar issue. There are no red flags or justification for a pain management consultation. Furthermore, the provider reported did not document lack of pain and functional improvement that require referral to a pain specialist. The requesting physician did not provide documentation supporting the medical necessity for a pain management evaluation with a specialist. The documentation did not include the reasons, the specific goals and end point for using the expertise of a specialist. Therefore, the request for pain management evaluation is not medically necessary.