

Case Number:	CM14-0136187		
Date Assigned:	09/03/2014	Date of Injury:	03/28/2013
Decision Date:	10/02/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	08/25/2014

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 & Rehabilitation, has a subspecialty in Interventional Spine 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 is a 52 year old male with date of injury 3/28/13. The treating physician report dated 7/24/14 indicates that the patient presents with pain affecting the higher lumbar spine that is rated a 7/10. The report states that the patient is status post RFA at L4/5 and L5/S1 that provided relief of his lower lumbar symptoms. The physical examination findings reveal pain to palpation over the L2, L3 and L4 region with decreased lumbar rotation and lateral bending with negative straight leg raising and positive facet loading on the right. The treating physician goes on to state that the patient has failed conservative therapy, has a 5mm disc herniation at L2/3 and L3/4 and did well with a radiofrequency of the lower lumbar levels and the patient is trying to avoid lumbar surgery. The current diagnoses are: 1.Obesity2.Lumbar degenerative disc disease3.Facet arthropathyThe utilization review report dated 8/14/14 denied the request for Medial branch nerve block at L2/3, L3/4 and L4/5 based on the ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial branch nerve block at L2-3, L3-4 and L4-5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Medial Branch Block Section

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

Decision rationale: The patient presents with chronic lower back pain that is rated a 7/10 with no evidence of radiculopathy. The current request is for Medial branch nerve block at L2-3, L3-4 and L4-5. The treating physician states the patient responded well to previous MBB and radiofrequency nerve ablation at L4/5 and L5/S1 and that the patient is having pain in the higher levels of the lumbar spine with lumbar extension, twisting, standing or bending. The treating physician has documented tenderness to palpation affecting L2, L3 and L4 with a normal sensory examination, negative straight leg raise and positive facet loading. The MTUS guidelines do not address facet block injections. The ODG guidelines state specifically the criteria used for facet joint pain injections which include, tenderness to palpation over the facet region, a normal sensory examination, absence of radicular findings and normal straight leg raising. The ODG guidelines go on to state that diagnostic blocks for facet mediated pain should be limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. In this case, the series of events are as follows: The patient started with 4/1/14 medial branch nerve root block that provided 100% relief of symptoms performed on the right side at L4/5 and L5/S1. The pain went from a 4-8/10 to a 1/10. On 4/17/14 the documented pain was going across the "lower back" and was rated a 7-8/10. Following apparent successful DMB block from 4/1/14, RF ablation was performed on 7/1/14 for the right sided L4/5, L5/1 median nerves. On 7/10/14 the patient was having increased pain "but when further asking the patient he is reporting that the pain is mainly on the left side and he is having muscle spasms. The right side is doing much better. He rates his pain today about a 7-8/10." Now the patient is presenting with "left-sided" pain mostly and the treater notes positive facet loading on the left. The patient is placed on Robaxin to 3-4/day along with Medrol Dosepak and follow up in two weeks. The next report is the 7/24/14 where the patient suddenly presents with "higher" lumbar pain with "pain to palpation over L2, L3 and L4, There is positive facet loading on the right. Positive FABER sign on the right. "Medrol dosepak provided some relief but the patient is not working." It would appear that the patient has responded with a classic placebo response following the previous RF ablation. There is no evidence that the patient has actually improved with no reduction in overall pain, functional improvement or any reduction in medication use. In fact, the patient has additional problems that were not present before and requiring more medications including Robaxin and Medrol dosepak. The patient has shifted over to the left side and then to the upper lumbar area with positive facet loading where ever the pain happens to be. ODG guidelines require not only pain reduction but functional improvement and medication reduction. Given that the patient is now having more problems following prior RF ablation, additional investigation of the facet joints for more and more RF ablation would not be consistent with ODG guidelines. The request is not medically necessary.