

Case Number:	CM14-0143504		
Date Assigned:	09/10/2014	Date of Injury:	02/16/2011
Decision Date:	11/06/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	09/04/2014

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 Occupational 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 claimant injured his low back on 02/16/11. Right L1-2 and L3-4 facet joint nerve blocks are under review. On 03/11/14, a lumbar ESI (epidural steroid injection) was recommended. On 04/08/14, the claimant had low back pain at level 4-8/10 that was intermittent and increased with his activity. He had radiating right lower extremity episodes. Medications were ordered. On 05/27/14, he still had pain and had a positive straight leg raise test on the right side at 60. On 07/08/14, he still had increased pain with his activity and it was improved with medications. Straight leg raise was positive. He was referred to pain management. He had an initial pain management consultation on 08/01/14. He has tried multiple treatment modalities including PT, TENS, heat, ice, acupuncture, and epidural steroid injections. He has had imaging studies. He had low back pain radiating to the right leg. It was relieved by lying on his back with pillows under his knees. Physical examination revealed muscle spasm and trigger points with twitch response. He had decreased range of motion and pain with facet loading bilaterally. Sensation was diminished in the bilateral L5 and S1 distributions and straight leg was positive on the left at 90 with back pain. SLR (straight leg raise) was positive on the right at 50 with low back pain and right lower extremity radiating pain. MRI showed a small disc protrusion at L1-2 and mild degenerative disc disease at L5 and S1. There was an annular tear at L1-2. He was diagnosed with facet arthropathy, sciatica, degenerative disc disease, herniated nucleus pulposus at L1-2, and osteoarthritis. Facet arthropathy was at L1, L2, and L3-4. Facet joint blocks were recommended. These findings were similar on 08/12/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L1-2 and L3-4 facet joint nerve block: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines web 2012 Low Back- facet joint diagnostic blocks (injections)

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, medial branch nerve blocks

Decision rationale: The history and documentation do not objectively support the request for right L1-2 and L3-4 facet joint nerve blocks. The MTUS do not address these types of injections. The ODG state "recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, 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. (Cohen, 2007) (Bogduk, 2000) (Cohen2, 2007) (Manchukonda, 2007) (Dreyfuss, 2000) (Manchikanti2, 2003) (Datta, 2009).... 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 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)...."The notes do not indicate that radiofrequency is under consideration based on the results of these injections. In this case, there also is evidence of radicular symptoms and findings (including sensory deficits). The ODG do not support facet joint injections of this type in such cases. There is no evidence that they are being recommended as a diagnostic procedure. The medical necessity of right L1-2 and L3-4 facet joint nerve blocks has not been demonstrated.