

Case Number:	CM14-0179124		
Date Assigned:	10/30/2014	Date of Injury:	10/16/2012
Decision Date:	12/05/2014	UR Denial Date:	10/10/2014
Priority:	Standard	Application Received:	10/10/2014

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:

The patient is a 32-year-old man who sustained a work related injury on October 16, 2012. Subsequently, he developed chronic low back pain. MRI of the lumbar spine dated November 21, 2012 showed intervertebral disc disease and degenerative changes of the lumbar spine. At the L5-S1 level, there is a 3-4 mm grade 1 retrolisthesis. There is a 1-2 mm grade 1 retrolisthesis at L4-5. At the L4-5 level, there is a left paracentral disc extrusion. No acute compression fracture. No significant paraspinal muscle or soft tissue contusion appreciated. The patient underwent a left-sided L5 and S1 transforaminal epidural steroid injection along with an L5-S1 translaminar lumbar epidural steroid injection on August 13, 2014 with only 50% of pain relief for 2 weeks and then the pain started to come back (per September 4, 2014 medical report). According to a follow-up report dated October 2, 2014, the patient reported severe constant low back pain axially radiating to the left foot with numbness. He rated his low back pain as a 7-8/10. His physical examination revealed a positive hyperextension maneuver of the lumbar spine. There was paracertebral muscle spasm and localized tenderness in lumbar facet joint at L4-5 and L5-S1. Range of motion of the lumbar spine was restricted. There was increased lumbar lordosis. Bilateral sitting straight leg raising was 60-70 degrees. Manual motor strength was 5/5. There were no sensory disturbances to light touch in legs. The patient was diagnosed with left paracentral disc protrusion at L4-5 and L5-S1, grade I retrolisthesis of L4-5, bilateral L4-5 and L5-S1 facet joint arthropathy, left sided L5 lumbar radiculopathy (EMG confirmed), lumbar sprain/strain, and chronic myofascial syndrome.. The provider requested authorization for Bilateral L4 and L5 medial branch blocks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L4 and L5 medial branch blocks: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: According 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 ODG guidelines regarding facets injections, < 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 and according to ODG guidelines, < 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. In this case, there is no documentation of facet mediated pain; There is no clear evidence or documentation that lumbar and sacral facets are main pain generator. The patient has , left sided L5 lumbar radiculopathy (EMG confirmed). Therefore, the Bilateral L4 and L5 medial branch blocks are not medically necessary.