

Case Number:	CM14-0064813		
Date Assigned:	07/11/2014	Date of Injury:	09/11/2008
Decision Date:	09/18/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/07/2014

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 55 year-old female who reported an injury on 09/11/2008 due to the injured worker picked up a box of chicken from the floor and felt a sharp pain in her back radiating to the right lateral leg. The injured worker had a history of lower back pain with diagnoses of mood disorder, sacroiliac pain, lumbar spinal degenerative disc disease, and low back pain. The MRI of the lumbar spine dated 04/15/2010 revealed multilevel hypertrophic facet changes associated with small facet joint effusions at the L3-4 and L4-5 and the overall appearance of the L-spine was stable and unchanged since 11/04/2008. The electromyogram dated 03/20/2014 revealed a normal study with bilateral lower extremities nerve conduction study that revealed no evidence of peripheral neuropathy. The electromyogram examination was also normal with no electrodiagnostic evidence of lumbar radiculopathy. The prior treatments included multiple lumbar epidural steroid injections. The objective findings dated 03/21/2014 of the lumbar spine revealed restricted range of motion with flexion limited at 45 degrees, extension limited at 5 degrees, moderate pain with extension the lumbar spine was right greater than left, lumbar facet tenderness over the L4, L5, and S1. Palpation to the paralumbar muscles revealed taut muscle band noticed bilaterally. The lumbar facet loading was positive bilaterally; the straight leg raise was positive. The injured worker had an antalgic gait, slow and stooped, with no assistive devices. The medications included Lidoderm 5% patch, Voltaren 1% gel, Cymbalta 60 mg, Soma 350 mg, Duragesic patch 50 mcg, Norco 10/325 mg, Lunesta 3 mg, Lorazepam 1 mg, and Trazodone 50 mg. The treatment plan included a medial branch block. The Request for Authorization dated 07/11/2014 was submitted with the documentation. The rationale for the medial branch block was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial Branch Block at L3, L4, L5 and Sacral (right side): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Lumbar Spine, 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 - Lumbar & Thoracic (Acute & Chronic), Facet Joint Diagnostic Blocks (injections).

Decision rationale: The Official Disability Guidelines recommend no more than 1 set of medial branch block diagnostic blocks per facet neurotomy. The criteria for the medial branch blocks include: 1 set of diagnostic medial branch blocks is required with a response of greater than 70%; the pain response should be at least 2 hours for Lidocaine; limited to patients with low back pain that is non-radicular; at no more than 2 levels bilaterally; there is documentation of a failure of conservative treatment including home exercise, physical therapy, and NSAIDs prior to the procedure for at least 4 to 6 weeks; no more than 2 facet joint levels are injected at 1 sessions; recommended volume is no more than 0.5 cc of injectate is given at each joint; no pain medication from home should be taken at least 4 hours prior to the diagnostic blocks and/or 4 to 6 hours afterwards; opioids should not be given as a sedative during the procedure; the use of IV sedation may be grounds to negate the results of the diagnostic block and should only be given in cases of extreme anxiety; the patient should document pain relief with the instruction of a VAS, emphasizing the important of recording the maximum pain relief and maximum duration of pain; the patient should also keep medication use activity logs to support the subjective report for better pain control; diagnostic facet blocks should not be performed in patients with whom a surgical procedure is anticipated; and diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at a planned injection level. The clinical notes the EMG or electromyelogram dated 03/01/2010 revealed evidence of right L5 radiculopathy, and again on 01/30/2012 the physician indicated that the injured worker had lower back pain that radiated to the right leg with numbness and decreased sensation. It also indicated a diagnosis of lumbar disc disease and lumbar radiculitis. The documentation dated 03/21/2014, indicated that the injured worker did not want any more procedures performed and that the medication was doing good controlling her pain. As such, the request is not medically necessary.