

Case Number:	CM13-0017717		
Date Assigned:	12/18/2013	Date of Injury:	12/19/2006
Decision Date:	05/22/2015	UR Denial Date:	08/05/2013
Priority:	Standard	Application Received:	08/28/2013

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Montana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 50 year old female, who sustained an industrial injury on 12/19/2006. The current diagnoses are thoracic degenerative disc disease at T7-8 and T8-9, lumbar degenerative disc disease at L5-S1, lumbar facet osteoarthritis at L4-5 and L5-S1, and bilateral sacroiliitis. According to the progress report dated 7/24/2013, the injured worker complains of thoracic and low back pain. The current medications are Percocet, Cymbalta, Voltaren gel, Ibuprofen, and Soma. Treatment to date has included medication management, heat/cold compresses, MRI studies, TENS unit, and injections. The plan of care includes bilateral L4-S1 medical branch facet injections and functional capacity evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient Medial Branch Facet Diagnostic Injections at the Bilateral L4-S1 Levels:

Overtured

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Facet joint diagnostic blocks (injections) and Facet joint injections multiple series.

Decision rationale: The MTUS, in the ACOEM guidelines, notes that 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, or 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. The ODG Guidelines note that diagnostic facet injections are recommend, with 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. 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a "sedative" during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008) The ODG guidelines note that facet joint injections in multiple series are not recommended. Diagnostic blocks: One set of medial branch blocks is recommended prior to a neurotomy. Intra-articular blocks are not recommended as the diagnostic procedure. Confirmatory blocks, while recommended for research studies, do not appear to be cost effective or to prevent the incidence of a false positive response to the neurotomy procedure itself. See Facet joint diagnostic blocks (injections). Therapeutic injections: With respect to facet joint intra-articular therapeutic injections, 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). See Facet joint intra-articular injections (therapeutic blocks). There is no peer-reviewed literature to support a "series" of therapeutic fact blocks. In this case the injured worker has a clinical presentation consistent with facet joint pain, signs & symptoms. The request for outpatient bilateral medial branch facet diagnostic blocks at L4-S1 is consistent with the published guidelines/criteria and is medically necessary.

Outpatient Functional Capacity Evaluation: 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): Chapter Fitness for Duty, Web Edition.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, Independent Medical Examinations and Consultations, pages 137-138 Official Disability Guidelines (ODG), Functional capacity evaluation (FCE).

Decision rationale: The ACOEM guidelines note that the examiner is responsible for determination of functional limitations and informing the injured worker and employer about work abilities and limitations. A functional capacity evaluation (FCE) may be requested to further evaluate current work capacity. Though functional capacity evaluations are widely used and promoted it is important for physicians and others to understand the limitations and pitfalls of these evaluations. Functional capacity evaluations may establish physical abilities, and also facilitate examine/employer relationship for return to work. There is little scientific evidence confirming that functional capacity evaluations predict an individual's actual capacity to perform in the workplace. An FCE reflects what an individual can do on a single day, at a particular time, under controlled circumstances, that provide an indication of that individuals abilities. The FCE is probably influenced by multiple nonmedical factors other than physical impairment. For these reasons it is problematic to rely solely upon the FCE results for determination of current work capability and restrictions. The ODG guidelines note that FCEs are recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. Not recommend routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. Guidelines for performing an FCE: Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. Consider an FCE if 1) Case management is hampered by complex issues such as: "Prior unsuccessful RTW attempts. Conflicting medical reporting on precautions and/or fitness for modified job". Injuries that require detailed exploration of a worker's abilities. 2) Timing is appropriate: "Close or at MMI/all key medical reports secured". Additional/secondary conditions clarified. Do not proceed with an FCE if "The sole purpose is to determine a worker's effort or compliance". The worker has returned to work and an ergonomic assessment has not been arranged. (WSIB, 2003) In this case there are work restrictions placed for no lifting greater than 5 pounds and no standing greater than 1 hour with frequent changes in position recommended. FCEs are preferred for assessments tailored to a specific task or job. In this case there is no job description available. No complex issues are

identified as noted in the above guidelines. It does not appear that the injured worker is at MMI. The FCE is not requested prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. There is not adequate documentation to support an FCE as noted in the above guidelines. The request for functional capacity evaluation is not medically necessary.