

Case Number:	CM14-0193879		
Date Assigned:	12/01/2014	Date of Injury:	04/22/2009
Decision Date:	01/14/2015	UR Denial Date:	11/10/2014
Priority:	Standard	Application Received:	11/19/2014

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, has a subspecialty in Pain 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 injured worker is a 37-year-old male who reported an injury on 04/22/2009. The mechanism of injury was not provided within the submitted medical records. The injured worker's diagnoses were listed as lumbar spondylosis and lumbago. Current medications were noted to include Percocet. Diagnostic studies included an official MRI completed on 09/13/2013 of the lumbar spine, read by [REDACTED], there was documented mild bilateral facet overgrowth at L2-3 and L3-4; at L5 there was tapering of the thecal sac; and at L5-S1 moderate facet hypertrophy with foraminal stenosis. The injured worker's surgical history was found to be unremarkable. Other therapies were noted to include injection therapy and stretching exercises. The clinical visit on 11/03/2014 documented the injured worker was complaining of lumbosacral spine pain with associated aching and tingling. The injured worker reported the pain to be a 6/10. The physical exam documented that the injured worker had decreased range of motion of the lumbar spine with bilateral facet loading signs and bilateral paraspinal muscle spasms. During the clinical visit on 08/01/2014, there is documentation that the injured worker had previously undergone lumbar medial branch blocks at L2, L3, L4, and L5 with no relief. The rationale provided for the request at this time is for relief of facet generated pain. A Request for Authorization was not provided within the submitted medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral medial branch blocks at L2, 3, 4, 5 with fluoroscopy and sedation x 2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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 request for bilateral medial branch blocks at L2, 3, 4, 5 with fluoroscopy and sedation x 2 is not medically necessary. The Official Disability Guidelines state that certain criteria must be met prior to the use of medial branch blocks. It is stated that after a successful set of diagnostic medial branch blocks there is a progression to radiofrequency neurotomy. To determine whether or not the medial branch blocks are successful, the guidelines state that there must be greater than 70% relief for at least 2 hours for lidocaine. The guidelines state that it should be limited to injured workers with low back pain that is nonradicular, and at no more than 2 levels bilaterally. There should also be documentation of a failure of conservative treatments. No more than 2 facet levels are recommended to be injected in 1 session. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. The guidelines also state that the injured worker should have documented pain relief with an instrument such as VAS, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. Within the submitted medical records there was no rationale provided as to why the injured worker was to undergo sedation for the procedure. Moreover, it was noted that the injured worker had previous bilateral medial branch blocks at the requested levels with the guidelines specifically stating that after the first set of blocks there should be a progression to radiofrequency neurotomys. Additionally, the requested procedure exceeds the guideline recommendation for only 2 levels. Without further documentation to address the aforementioned deficiencies outlined in the review, the request at this time is not supported by the guidelines. As such, the request is not medically necessary.