

Case Number:	CM14-0198505		
Date Assigned:	12/08/2014	Date of Injury:	05/09/2013
Decision Date:	01/21/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/25/2014

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 Neoromuscular 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 47-year-old man who sustained a work-related injury on May 9, 2013. Subsequently, the patient developed a chronic low back and knee pain. Prior treatments include: medications, right knee arthroscopic surgery done in October of 2013, physical therapy, and cortisone shot and synvisc shots at the right knee (failed). The patient MRI performed on 2013, demonstrated disc protrusion. According to a progress report dated on August 14 2014, the patient was complaining of ongoing back pain with a severity rated 3/10. MRI of the lumbar spine from June 6, 2014 showed congenital narrowing of the central canal and mild facet degeneration changes at multiple levels without significant central canal or neural foraminal stenosis. According to a progress report dated October 1, 2014, the patient had been experiencing difficulty sleeping, psychological problems, pain for more than 2 weeks, headaches, dizziness, loss of balance, metabolic disorder, sexual dysfunction, and scarring of the skin. The patient continued to have pain and did not improve post right knee surgery. The pain was somewhat diffuse. There was swelling and the knee could give away at times. On examination, straight leg raising test was negative. Patrick's test was negative. Facet loading was positive. Sensation was decreased to light touch in the right foot and weakness in the right knee extension. There was tenderness to palpation over the lumbar paraspinal muscles. There was tenderness to palpation over the bilateral knees with crepitation noted bilaterally. Anterior drawer test was positive on the right. There was positive laxity on the left knee with positive valgus stress test. The patient was diagnosed with lumbago, lumbar facet dysfunction that seems to have been aggravated by limping, depression secondary to pain, bilateral knee pain with degenerative joint disease and meniscus tear, left knee laxity and pain, chronic pain syndrome, and opioid dependence. The provider requested authorization for 6 bilateral lumbar facet medial branch blocks L3, L4 and L5 w/ fluoroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Bilateral lumbar facet medial branch blocks L3, L4 and L5 w/ fluoroscopy: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: According 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. 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 L3-5 facets are main pain generator. There is no evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. MTUS guidelines do not recommend more than 2 joint levels to be blocked at any one time. Therefore, the request for 6 bilateral lumbar facet medial branch blocks L3, L4 and L5 w/ fluoroscopy is not medically necessary.