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| Case Number: | CM14-0201652 | | |
| Date Assigned: | 12/11/2014 | Date of Injury: | 06/20/2008 |
| Decision Date: | 02/04/2015 | UR Denial Date: | 11/18/2014 |
| Priority: | Standard | Application Received: | 12/01/2014 |

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 61 year old man who sustained a work-related injury on June 20 2008. Subsequently, the patient developed a chronic. According to a progress report dated on July 21 2014, the patient was complaining of ongoing back pain despite lumbar performed 2 years ago. The patient physical examination demonstrated antalgic gait with the requested. Lumbar range of motion within the positive lumbar facet loading and positive straight leg raise on the left side. There is also decreased sensation in the S1 distribution and reduced strength plantar flexion. According to another progress note dated on 11/30/2014, the patient was complaining of chronic pain syndrome with a severity rated 8/10 without pain medications and 6/10 with pain medications. The patient reported the excellent relief of neck pain after nerve root injection. His physical examination was unchanged The patient was diagnosed with. The provider requested authorization for L2 communicans rami block.

IMR ISSUES, DECISIONS AND RATIONALES

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

L2 communicans rami block: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Brittish Journal of Anesthesia; 10.1093/bja/aep168; 2009: Bilateral L1 and L2 dorsal root ganglion blocks for discogenic low back pain. J. Richardson, N. Collinghan, A.J. Scally and S. Gupta: last updated 01/01/2009

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 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 that facets are the main generator of pain. 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 facet injection if there is suspicion of radiculopathy. The patient in this case was diagnosed with radiculopathy. Therefore, the request for L2 communicans rami block is not medically necessary.