

Case Number:	CM14-0201948		
Date Assigned:	12/12/2014	Date of Injury:	08/13/2008
Decision Date:	01/30/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/03/2014

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 54-year-old woman who sustained a work-related injury on August 13, 2008. Subsequently, the patient developed chronic low back pain. The patient underwent fusion at L3-4 and L4-5 on February 13, 2012 with XLIF. Prior treatments also included: anti-inflammatory medications, muscle relaxants, physical therapy, epidural steroid injections (last injection being on February 22, 2011), and right L2-3 and L5-S1 TFESI (on July 1, 2014). According to a progress report dated November 11, 2014, the patient complained of worsening back pain (predominantly lower back pain). The pain was related to her facet area. The patient has had significant flare up, that, according to [REDACTED], was likely a result of the facet pathology. Examination of the lumbar spine revealed pain and tenderness to palpation over the facet joints. There was limited extension due to the facet pain. Motor strength was 5/5 proximally and distally. Sensory was intact in the bilateral lower extremities. Deep tendon reflexes was 1+ for left lower extremity. Babinski absent. Clonus absent. FABER negative bilaterally. X-rays of the lumbar spine dated April 21, 2014 showed a stable, residual spondylolisthesis. There was no motion in flexion or extension at L4-5. L5-S1 does appear to be narrowed. MRI of the lumbar spine dated May 13, 2014 showed a good solid fusion at L3-4 and L4-5. Residual stenosis was noted. The L2-3 posterior disc extrusion was causing bilateral as well as lateral recess stenosis. There was L5-S1 facet arthropathy causing severe bilateral neural foraminal stenosis as well. The patient was diagnosed with facet syndrome at L3-4, L4-5, and L5-S1, status post XLIF fusion at L3-4 and L4-5, adjacent disc pathology at L5-S1 and foraminal stenosis with combination of facet and disc pathology, L2-3 disc extrusion, and low back pain. The provider requested authorization for L3-4, L4-5, L5-S1 bilateral facet medial branch blocks with fluoroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

One L3-4, L4-5, L5-S1 bilateral facet medial branch blocks with fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guideline, Low Back- Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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. 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 (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti, 2003) (Boswell, 2005) 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, the L5-S1 bilateral facet medial branch block with fluoroscopy was certified while the facet medial branch blocks at L3-4 and L4-5 were not certified. 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 medial branch block. MTUS guidelines do not recommend more than 2 joint levels to be blocked at any one time. Therefore, the request for L3-4, L4-5, L5-S1 bilateral facet medial branch blocks with fluoroscopy is not medically necessary.