

Case Number:	CM14-0202387		
Date Assigned:	12/12/2014	Date of Injury:	01/16/2012
Decision Date:	02/04/2015	UR Denial Date:	11/21/2014
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 35-year-old man who sustained a work-related injury on January 16, 2012. Subsequently, he developed chronic low back pain. MRI of the lumbar spine dated January 10, 2014 showed degenerative disc disease with neural foraminal narrowing at each level from L2-3 to L5-S1. There was mild spinal canal stenosis at L3-4 and L4-5, unchanged. There was no significant interval changes compared to MRI April 11, 2012. According to a progress report dated October 22, 2014, the patient stated that his low back pain is about the same: sharp and burning. He rated the level of his pain as a 4/10. It was intermittent in nature. The pain was being treated with Motrin, occasional Norco and Prilosec. The patient has been authorized for physical therapy, but has had difficulties with transportation. Examination of the lumbar spine revealed lumbar paraspinal tenderness and spasm. The range of motion was limited by pain. Seated straight leg raise was negative bilaterally. Femoral stretch testing was negative. Supine straight leg raising was negative bilaterally. Faber test was negative. Piriformis stretch was negative. Facet load test was negative. Lumbar facet stress test was positive. Motor strength examination was 5/5 and light touch sensation was intact. Deep tendon reflexes were 2/4 bilaterally. The patient was diagnosed with lumbar sprain/strain and lumbar facet arthropathy. The provider requested authorization for Lumbar medical branch block bilateral L3-L5 under fluoroscopic guidance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar medical branch block bilateral L3-L5 under fluoroscopic guidance (qty: 6):
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Low Back (updated 10/28/14) Facet joint intra-articular injections (therapeutic blocks)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

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. (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, there is no documentation of facet mediated pain; There is no clear evidence or documentation that lumbar and sacral facets are main pain generator. Therefore, the request for Lumbar medical branch block bilateral L3-L5 under fluoroscopic guidance is not medically necessary.