

Case Number:	CM15-0192088		
Date Assigned:	10/06/2015	Date of Injury:	06/28/2012
Decision Date:	11/18/2015	UR Denial Date:	09/17/2015
Priority:	Standard	Application Received:	09/30/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 44-year-old male injured worker suffered an industrial injury on 6-28-2012. The diagnoses included bilateral low back pain, left worse than right, left posterior lateral thigh and leg pain, left Achilles' tendon pain and ruptured Achilles' tendon, lumbosacral spondylosis without myelopathy, lumbosacral degenerative disc disease. On 9-4-2015, the treating provider reported the injured worker had numbness and tingling primarily on the left leg and while experiencing a numbness sensation in the left leg he felt a pop and a large swelling in the left Achilles' tendon. "Eventually this was diagnosed as a ruptured Achilles' tendon." The pain was described in the bilateral lower lumbar left side worse than right bilateral gluteal and left leg anterior posterior thigh and calf. The pain at worst was 9 out of 10 and least 5 out of 10. The pain was burning, throbbing and stabbing with associated symptoms of numbness and tingling in the left leg with pins and needles in the toes of the feet. The provider noted the electromyography studies showed no signs of radiculopathy. He stated, "the fundamental question which remains unanswered as how much of the pain is facet generated and this can be only answered with diagnostic lumbar facet blocks." If positive, the radiofrequency ablation would be recommended. Prior treatment included physical therapy, medications, chiropractic therapy, facet joint injections and transforaminal epidural steroid injections. Diagnostics included 3-23-2015 lumbar magnetic resonance imaging that revealed right paracentral disc protrusion at L5-S1. Disc material contacts the right S1 nerve root. There is a right paracentral annular tear associated with the disc protrusions, and Lumbar x-rays revealed degenerative disc disease that worsened. The

Utilization Review on 9-17-2015 determined non-certification for Diagnostic bilateral medial branch blocks at L3, L4 and L5.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic bilateral medial branch blocks at L3, L4 and L5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Criteria for the use of diagnostic blocks for fact "mediated" pain.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, under Facet Joint Diagnostic Blocks.

Decision rationale: The patient presents on 09/04/15 with lower back pain rated 5/10 at best (9/10 at worst) which radiates into the left lower extremity with associated numbness and tingling in the affected limb. The patient's date of injury is 06/28/12. Patient is status post lumbar ESI at L5-S1 levels on 08/08/14. The request is for DIAGNOSTIC MEDIAL BRANCH BLOCKS AT L3, L4, AND L5. The RFA is dated 09/04/15. Progress note dated 09/04/15 does not include a comprehensive physical examination, only a review of systems, case history, and past treatments. The patient is currently prescribed Gabapentin, Naproxen, Norco and Flexeril. Patient's current work status is not provided. ODG Low Back Chapter, under Facet Joint Diagnostic Blocks states: Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment - a procedure that is still considered "under study". Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block. Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. Criteria for the use of diagnostic blocks for facet "mediated" pain: 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. MTUS/ACOEM Practice Guidelines, Chapter 12, Low Back complaints, page 300, under Physical Methods states: "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit." About the request for a diagnostic facet block directed at the L3 through L5 levels, the patient does not meet guideline criteria. There is no indication in the documentation if this patient has undergone any lumbar facet block injections to date. Guidelines do not support such procedures in patients who present with radicular pain. This patient presents with chronic lower back pain, which radiates into the left lower extremity with evidence of

neurological compromise in the affected limb. Per progress note dated 09/04/15, the provider states: "The unanswered question remains whether most of his pain is facet generated or whether it is discogenic... facet pain can mimic radicular type pain. The fundamental question which remains unanswered as how much of the pain is facet generated and this can be only answered with diagnostic lumbar facet blocks." While this patient presents with chronic lower back pain poorly controlled by other measures, the presence of radiculopathy in this patient precludes lumbar facet injections, diagnostic or otherwise. Therefore, the request IS NOT medically necessary.