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| Case Number: | CM15-0200743 | | |
| Date Assigned: | 10/15/2015 | Date of Injury: | 04/17/2001 |
| Decision Date: | 11/24/2015 | UR Denial Date: | 09/23/2015 |
| Priority: | Standard | Application Received: | 10/13/2015 |

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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 injured worker is a 40 year old female, who sustained an industrial injury on 4-17-01. The documentation on 9-16-15 noted that the injured worker has complaints of low back and left shoulder pain. The injured worker has a slow antalgic gait and she uses a cane for gait assistance. There is pain on 10 degrees of forward flexion; extension is 5 degrees and left and right lateral bend is 5 degrees. There is heel and toe step pain with weakness and straight leg raise is positive to 50 degrees. The documentation on 8-26-15 noted that the injured workers pain level is rates 7 out of 10 in intensity on average with medications and 9 to 10 out of 10 without medications. Lumbar spine magnetic resonance imaging (MRI) on 8-11-15 revealed status post bipedicular fusion at the L4-S1 (sacroiliac) levels with inner vertebral disk grafts present and laminectomy changes at these levels; mild broad-based bulges at the L2-3 and L3-4 levels with mild central canal stenosis at L3-4; mild central canal stenosis, bilateral subarticular recess and bilateral neural foraminal stenosis at L4-5; recommend correlation with bilateral L4 radiculopathy and mild bilateral neural foraminal stenosis at L5-S1 (sacroiliac). The diagnoses have included chronic pain other; lumbar facet arthropathy; failed back surgery syndrome, lumbar; lumbar radiculopathy and lumbosacral spondylosis without myelopathy. Treatment to date has included lumbar spine fusion with residuals; right shoulder arthroscopy; carpal tunnel release and De Quervain's release; caudal epidural steroid injection and opioid pain medications. The original utilization review (9-23-15) non-certified the request for bilateral L3-L5 median branch nerve block under fluoroscopy quantity 4.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L3-L5 median branch nerve block under fluoroscopy qty: 4.00: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Facet joint therapeutic steroid injections.

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 under Medical Branch Blocks, Diagnostic.

Decision rationale: This claimant was injured in 2001, now 14 years ago, with low back and left shoulder pain. Treatment to date has included lumbar spine fusion with residuals; right shoulder arthroscopy; carpal tunnel release and De Quervain's release; caudal epidural steroid injection and opioid pain medications. This is a request for medial branch facet blocks. The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. Per the California MTUS-ACOEM guidelines, Chapter 12, under physical methods, page 300: 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. The ODG notes: Criteria for the use of diagnostic blocks for facet mediated pain: 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 joint levels are injected in one session (see above for medial branch block levels). 5. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 6. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. The MTUS is not overtly supportive. Also, the surgical plans in this claimant is not clear. The request is not medically necessary.