

Case Number:	CM15-0210863		
Date Assigned:	10/29/2015	Date of Injury:	08/05/2014
Decision Date:	12/11/2015	UR Denial Date:	09/28/2015
Priority:	Standard	Application Received:	10/27/2015

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: Arizona, California

Certification(s)/Specialty: Family Practice

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 55-year-old male, with a reported date of injury of 08-05-2015. The diagnoses include low back pain, lumbar radiculopathy, lumbar spinal stenosis, fracture of lumbar vertebra-close, and fracture of fourth lumbar vertebra. The medical report dated 09-10-2015 indicates that the injured worker felt that he had stayed the same since the last visit. The injured worker had low back pain, which is predominately in the region of the right paravertebral lumbar and lumbosacral spine bilaterally. It was reported that the pain was also over the region of the facet joints. It was noted that the injured worker had numbness radiating into his anterior thigh, right greater than the left, and in the L3 distribution. On 07-28-2015, it was noted that the injured worker rated his low back pain 6 out of 10 without medications, and 3 out of 10 with medication. On 06-30-2015, there was documentation that the injured worker rated his pain 6 out of 10 without medication, and 2-3 out 10 with medication. The objective findings include tenderness to palpation in the mid to slightly lower lumbar region; no kyphotic, scoliotic, or lordotic deformities; some exacerbation of his pain with extension and rotation and some bilateral paraspinal muscle guarding and spasms; a normal gait; intact sensation to light touch, pinprick, and joint position throughout; and limited range of motion in all arcs of the lumbar spine. It was noted that the injured worker would return to work with restrictions. The diagnostic studies to date have included a urine drug screen on 05-22-2015 with inconsistent findings for Tramadol; an MRI of the lumbar spine on 10-20-2014 showed acute to subacute Schmorl's node to the L3 superior endplate with minor loss of height along the superior endplate, and multilevel multifactorial changes through the lumbar spine most notable at L3-4 and L4-5 for neural foraminal stenosis; a CT scan of the lumbar spine on 08-05-2014 showed an L4 superior end-plate compression fracture; an MRI of the lumbar spine on 08-29-2014 showed a mild compression

deformity within the anterior and superior chip fracture of the L4, mild disc bulging at L3-4 and L4-5 with desiccation at L4-5, and some facet arthropathy at L4-5; and x-rays of the lumbar spine on 08-06-2014 and 08-07-2014 showed an L4 superior end-plate compression fracture with a small anterior and superior chip component. Treatments and evaluation to date have included Tramadol, physical therapy (noted as failed), Hydrocodone, and Meloxicam. The request for authorization was dated 09-10-2015. The treating physician requested bilateral L2, L3, and L4 medial branch blocks at the L3-4 and L4-5 facets due to the fact that the injured worker had exacerbation of pain with extension and rotation and paravertebral muscle guarding and spasms. The treating physician also mentioned that the injured worker wanted to pursue invasive measures. On 09-28-2015, Utilization Review (UR) non-certified the request for bilateral L2, L3, and L4 medial branch blocks at the L3-4 and L4-5 facets.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L2, L3 and L4 medial branch blocks at the L3-L4 and L4-L5 facets: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter and pg 36.

Decision rationale: According to the guidelines, Criteria for the use of diagnostic blocks for facet "mediated" pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 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 facet joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a "sedative" during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. According to the ACOEM guidelines, blocks are not recommended due to their short-term benefit. The MTUS guidelines recommend blocks for those who failed conservative therapy and have no radiculopathy on exam or imaging and not prior fusion. Repeat blocks are indicated for those who have sustained at least 70% relief. In this case, therapy was requested several times, but documentation was not provided on its completion or benefit. The claimant had good pain control with medications. The use of a medial branch block is not medically necessary based on the guidelines above.