MAXIMUS Federal Services

Case Number:	CM15-0212694		
Date Assigned:	11/02/2015	Date of Injury:	01/30/2002
Decision Date:	12/16/2015	UR Denial Date:	09/29/2015
Priority:	Standard	Application Received:	10/29/2015

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: New York, Tennessee
Certification(s)/Specialty: Emergency 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 41 year old, male who sustained a work related injury on 1-30-02. A review of the medical records shows he is being treated for lower back pain. In the Follow-Up Physiatry Pain Evaluation Report dated 8-3-15 and progress notes dated 8-20-15, the injured worker reports lower back pain that radiates to both legs. He rates his pain level a 7 out of 10. With medications, he rates his pain level a 6 out of 10 and without medications, the pain level is 9 out of 10. He reports neck pain. On physical exam dated 8-20-15, he has tenderness to palpation of facets. He has limited lumbar extension. Treatments have included medications, lumbar spine surgery, physical therapy-unknown number of sessions, home exercises and ice-heat therapy. There is no documentation of the results of physical therapy sessions. There is a notation on a progress report dated 5-12-15 that "physical therapy is proving effective in improving patient's pain levels, function, range of motion and overall sense of comfort." There is no documentation of previous lumbar epidural steroid injections. Current medications include Norco and Butrans patches. Working status is not noted. The treatment plan includes a recommendation for facet diagnostic median branch blocks, medications and depression treatment. In the Utilization Review dated 9-29-15, the requested treatments of bilateral L3-4, L4-5, L5-S1 facet median branch block with fluoroscopy, a cognitive behavioral consultation and a follow-up appointment are all not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L3-4, L4-5, L5-S1 facet median branch block with fluoroscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back: Thoracic and Lumbar, Facet joint Mediated Blocks.

Decision rationale: No more than one set of medial branch diagnostic blocks is recommended 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. Facet joint medial branch blocks are not recommended for therapeutic use. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). 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. Etiology of false positive blocks is: Placebo response, use of sedation, liberal use of local anesthetic, and spread of injectate to other pain generators. The concomitant use of sedative during the block can also interfere with an accurate diagnosis.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. In this case, the patient has radicular symptoms with decreased sensation in both lower extremities. In addition, the number of levels requested surpasses the recommended

maximum of 2 levels. Criteria for median branch block have not been met. The request is not medically necessary.

CBT consult: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological treatment. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain, Behavioral Interventions.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that psychological treatment is recommended for appropriately identified patients during treatment for chronic pain. The guidelines also state that psychological intervention includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders. Screening is recommended for patients with risk factors for delayed recovery, including fear avoidance beliefs. In this case, there is no documentation that screening for cognitive behavioral therapy has been completed. Medical necessity has not been established. The request should not be authorized.

Follow up appt.: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back.Lumbar & Thoracic: Office visits.

Decision rationale: Office visits are recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The number of office visits automatically covered for an established patient is six. In this case the patient's injury was in 2002. Office visits have occurred on July 6, August 3, August 20, August 31, and September 28. The patient is now in the maintenance phase of his treatment and does not require more than 6 office

visits yearly. The request is not medically necessary.