

Case Number:	CM15-0049020		
Date Assigned:	03/20/2015	Date of Injury:	12/08/2009
Decision Date:	05/01/2015	UR Denial Date:	03/10/2015
Priority:	Standard	Application Received:	03/16/2015

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 34 year old female who sustained an industrial injury on December 8, 2009. Latest diagnostic studies were a Computed Tomography (CT) of the cervical spine in September 2013 and a lumbar magnetic resonance imaging (MRI) in January 2011. The injured worker is status post C6-7 anterior cervical discectomy and fusion in May 2011 and a right cubital tunnel release in March 2013. The injured worker was diagnosed with right cervical radiculopathy post-operatively, status post right cubital tunnel release with subluxing ulnar nerve, L4-S1 facet arthropathy, retrolisthesis of L2 on L3 and left greater than right lumbar radiculopathy. According to the primary treating physician's progress report on February 27, 2015, the patient continues to experience neck and low back pain, left elbow and left knee pain. Examination of the lumbar spine and lower extremities demonstrated no swelling and no atrophy of the paravertebral muscles. There was tenderness to palpation of the paravertebral muscles bilaterally with tenderness over the coccyx. The injured worker had a positive facet loading test. Range of motion was full with some pain on extension. There was bilateral negative straight leg raise. Treatment plan consists of the request for authorization for bilateral L4-S1 medial branch block (4 units) and continue current medications of Vicodin, Motrin and Ambien with a random urine toxicology screening.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L4-S1 medial branch blocks (4 units): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Lumbar MBB- Diagnostic block - ODG 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. (Resnick, 2005)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 claimant had chronic back pain without complete resolution after undergoing conservative treatment, In addition, the claimant did not have radicular findings. However, the guidelines recommend the injection be performed under fluoroscopy and attain at least 70% improvement. In this case, the request for 4 units of injections in advance of knowing the therapeutic response exceeds the guidelines recommendations and is not medically necessary.