

Case Number:	CM15-0084645		
Date Assigned:	05/08/2015	Date of Injury:	04/23/1999
Decision Date:	06/05/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	05/05/2015

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 52-year-old male, who sustained cumulative industrial injuries from April 23, 1999 through November 4, 2005. He reported constant low back pain and right knee pain. The injured worker was diagnosed as having failed back surgery syndrome, permanent implantation of spinal cord stimulator, right lumbar radiculitis and sciatica, moderate disc degeneration confirmed with x-ray study, chronic myofascial pain syndrome and status post partial right knee replacement. Treatment to date has included radiographic imaging, diagnostic studies, surgical intervention of the lumbar spine and right knee, conservative therapies, medications and work restrictions. Currently, the injured worker complains of continued pain in the low back and right knee with radiating pain, tingling and numbness to bilateral lower extremities, right worse than left. The injured worker reported an industrial injury in 1999, resulting in the above noted pain. He was treated conservatively and surgically without complete resolution of the pain. Evaluation on May 22, 2014, revealed continued pain as noted. It was noted he was awaiting needle electro diagnostic studies of the bilateral lower extremities secondary to radicular pain. Evaluation on September 9, 2010, revealed continued constant pain with associated symptoms. Electro diagnostic studies revealed radiculopathy of the right leg from the lumbar spine. Evaluation on November 11, 2014, revealed continued pain. He reported up to a 70% improvement with recent lumbar steroid injection. Bilateral medial branch blocks of the lumbar spine were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L4-L5 Medial Branch Blocks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- low back pain 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. (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 progress note on 11/2014 indicated the claimant did have lumbar radiculopathy as demonstrated on EMG. The claimant already had prior invasive procedures including ESI. The ACOEM guidelines do not recommend injections due to short-term benefit. The claimant's findings do not meet the criteria above. The request for L4-L5 MBB is not medically necessary.