

Case Number:	CM15-0087817		
Date Assigned:	05/12/2015	Date of Injury:	03/04/2013
Decision Date:	06/17/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	05/07/2015

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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

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 47-year-old male patient who sustained an industrial injury on 03/04/2013. The accident described the patient carrying heavy objects with the acute onset of low back pain occurring while performing job duties. A recent note dated 04/24/2015 described a weekly report from the functional restoration program with the patient having subjective complaint of low back pain that radiates to bilateral lower extremities associated with numbness, tingling, and weakness of legs. He reports the symptoms worsening since the injury. He takes Gabapentin, and Colace. He also has diabetes and states that the sensations of parasthesia's to legs have worsened over time. Objective findings showed the patient outwardly depressed and deconditioned. Musculoskeletal examination found lumbar spine with limited rotation, and tenderness to palpation over the bilateral lumbar paraspinal muscles consistent with spasms. There is positive straight leg raise on the left along with sacroiliac tenderness on the left. The plan of care one week into the functional restoration programs with recommendation for additional days of restorative treatment avoiding any delay in treatment. He is temporary totally disabled until the completion of the program. A primary treating office visit dated 12/01/2014 reported the treating diagnoses as lumbar radiculopathy secondary to herniation without myelopathy. There is recommendation to undergo a lumbar epidural steroid injection. The patient is found to have failed all medical treatment options, but remains functionally impaired and there has been a delay in returning to work. Surgical intervention is not an option at this time. The recommendation was to evaluate the patient for a functional restoration program. Medications refilled this visit include Neurontin 600mg, Flexeril, and Docuprene.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral lumbar facet joint block injections at the levels of L4-L5 and L5-S1 under fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Facet joint diagnostic blocks (injections).

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, Facet Blocks.

Decision rationale: According to the ODG, the 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 injured workers with 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 injured worker 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 injured worker 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 injured workers in whom a surgical procedure is anticipated. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed in injured workers who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review previous fusion at the targeted level. (Franklin, 2008)] According to the documents available for review, the IW complains of lumbar back pain with radiation into the lower extremities and carries a diagnosis of lumbar radiculopathy. Further, physical exam demonstrates negative lumbar facet loading. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established. This request is not medically necessary.