MAXIMUS Federal Services

Case Number:	CM14-0093519		
Date Assigned:	07/25/2014	Date of Injury:	12/21/2012
Decision Date:	09/16/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/20/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant injured her low back on 12/21/12. Right lumbar medial branch blocks at levels L3-4 and L4-5 are under review. The claimant sustained cumulative trauma due to sitting in a jump seat for several weeks. She was diagnosed with low back pain, lumbosacral spondylosis and facet joint arthritis. A lumbar MRI dated 02/20/13 showed degenerative disc disease and facet osteoarthritis from L3-4 to L5-S1 causing no significant central stenosis or foraminal narrowing and mild central stenosis and effacement of the right lateral recess at L3-4. On 05/27/14, she had 7-10/10 right lower back pain radiating to the right buttock with stiffness and spasm. She had had medications, PT, chiropractic, acupuncture, epidural steroid injections without benefit and facet injections on 06/24/13 (L4-5 and L5-S1) with pain relief for days to a week. Range of motion was limited and sensation was intact. Her strength was intact. Medial branch blocks were recommended. The medial branch blocks were modified and sedation was non-certified. She saw [redacted] on 03/31/14 and reported increased pain with flexion and increased pain with extension of the back limited to 1 degree. Straight leg raise was minimally positive on the right at 85-90. There were no clear neurologic deficits. On 12/16/13, there was no evidence of radiculopathy though she had disc disease. She also had facet arthritis. She had similar findings in February 2014. Facet joint medial branch blocks at levels L3-4 and L4-5 with sedation have now been recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L3-4 and L4-5 medial branch block with fluroscopy guidance and sedation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diagnostic Blocks for Facet pain.

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, Medial Branch Blocks, Pain Physician 2005, Boswell, 2005, Manchikanti, 2001, Cohen, 2014.

Decision rationale: The history and documentation do not objectively support the request for right L3-4 and L4-5 medial branch blocks at this time. The MTUS do not address facet joint injections. Per ODG state facet joint medial branch blocks are "not recommended except as a diagnostic tool." and there is minimal evidence for treatment. Per Pain Physician 2005, published an article that stated; "that there was moderate evidence for the use of lumbar medial branch blocks for the treatment of chronic lumbar spinal pain." (Boswell, 2005) This was supported by one study. (Manchikanti, 2001) Patients either received a local anesthetic or a local anesthetic with methyl prednisolone. Also, all blocks included Sarapin, and sixty percent of the patients overall underwent seven or more procedures over the year study period, and over 13 to 32 months. There were more procedures recorded for the group that received corticosteroids that those that did not (301 vs. 210, respectively). ["Moderate evidence" is a definition of the quality of evidence to support a treatment outcome according to Pain Physician.] The average relief per procedure was 11.9 in 3.7 weeks.Pain Physician 2007: This review included an additional randomized controlled trial. (Manchikanti2, 2007) Controlled blocks with local anesthetic were used for the diagnosis (80% reduction of pain required). Four study groups were assigned with 15 patients in each group: (1) bupivacaine only; (2) bupivacaine plus Sarapin; (3) bupivacaine plus steroid; and (4) bupivacaine, steroid and Sarapin. There was no placebo group. Doses of 1-2ml were utilized. The average number of treatments was 3.7 and there was no significant difference in number of procedures noted between the steroid and non-steroid group. Long-term improvement was only thought to be possible with repeat interventions. All groups were significantly improved from baseline (a final Numeric Rating Scale score in a range from 3.5 to 3.9 for each group). Significant improvement occurred in the Oswestry score from baseline in all groups, but there was also no significant difference between the groups. There was no significant difference in opioid intake or employment status. There was no explanation posited of why there was no difference in results between the steroid and non-steroid groups. This study was considered positive for both short- and long-term relief, although, as noted, repeated injections were required for a long-term effect. Based on the inclusion of this study the overall conclusion was changed to suggest that the evidence for therapeutic medial branch blocks was moderate for both short- and long-term pain relief. (Boswell2, 2007) Psychiatric comorbidity is associated with substantially diminished pain relief after a medial branch block injection performed with steroid at one-month follow-up. These findings illustrate the importance of assessing comorbid psychopathology as part of a spine care evaluation. (Wasan, 2009) The use of the blocks for diagnostic purposes is discussed in Facet joint diagnostic blocks (injections)." ODG further states "Etiology of false positive blocks: Placebo response (18-32%), 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. (Cohen, 2007) The use of sedation during diagnostic injections may increase the rate of false-positive blocks and lead to

misdiagnoses and unnecessary procedures, but has no effect on satisfaction or outcomes at 1-month. (Cohen, 2014)"In this case, there is no indication that the original medial branch blocks were diagnostic and followed by radiofrequency following temporary pain relief. One block is recommended for diagnostic purposes, prior to consideration of radiofrequency ablation and it is not clear why a second block has been recommended for level L4-5. Also, it is not clear why different levels (now including L3-4) are being targeted. There is no evidence that the claimant has been involved in any kind of exercise program or has been advised to continue an exercise program, even just stretching, along with injection therapy. In addition, since sedation may cause false positive blocks and there is no evidence of significant anxiety, the medical necessity of sedation during these injections has not been shown. Also, since the injections are not medically necessary, the sedation is also not medically necessary. The medical necessity of this request has not been clearly demonstrated.