

Case Number:	CM14-0099431		
Date Assigned:	09/16/2014	Date of Injury:	10/19/1993
Decision Date:	10/07/2014	UR Denial Date:	06/09/2014
Priority:	Standard	Application Received:	06/27/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 patient is a 60-year-old man who sustained a work-related injury on October 19, 1993. Subsequently, he developed with chronic back pain. The patient underwent left L4-L5 transforaminal epidural steroid injection on January 24, 2013 and the multiple lumbar radiofrequency rhizotomies at the level of L3-L4 and L4-L5 and L5-S1 bilaterally on August 16, 2013. The patient has significant but transitory improvement of his condition after having low both procedures. According to a progress note dated on April 16, 2014, the patient was complaining of progressive worsening back pain. The pain severity was the 3-4/10 with pain medications. His physical examination demonstrated no tenderness over the sacroiliac joints and no objective musculoskeletal findings. The patient was diagnosed with chronic lumbar pain related to facet arthropathy, left sacroiliac dysfunction and muscle spasm. The provider requested authorization to repeat medial branch facet radiofrequency rhizotomy for bilateral L3, L4, and L5.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Management repeat medial branch facet radiofrequency rhizotomy for bilateral L3, L4, L5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 300-301.
Decision based on Non-MTUS Citation Official Disability Guidelines: Low back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) < Facet joint intra-articular injections (therapeutic blocks) (http://worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#Facetjointinjections).>

Decision rationale: According MTUS guidelines, <Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain. According to ODG guidelines regarding facets injections under study, current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial. Furthermore and according to ODG guidelines criteria for use of therapeutic intra-articular and medial branch blocks, are as follows, no more than one therapeutic intra-articular block is recommended, there should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive), no more than 2 joint levels may be blocked at any one time, there should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. According to MTUS guidelines, there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks.> The ODG guidelines did not support facet injection for lumbar pain in this clinical context. There is no documentation of facet mediated pain. The guidelines do not allow facet injection for more than 2 joint levels. In addition, there is no clear evidence or documentation that lumbar facets are main pain generator. Therefore, the request for Pain Management repeat medial branch facet radiofrequency rhizotomy for bilateral L3, L4, and L5 is not medically necessary.