

Case Number:	CM14-0192562		
Date Assigned:	11/26/2014	Date of Injury:	06/15/2010
Decision Date:	01/16/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	11/18/2014

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 injured worker is a 66-year-old male, with a reported date of injury of 06/15/2010. The result of injury was low back pain. The diagnoses include lumbar spine degenerative disc disease and stenosis of the lumbar region. Treatments have included physical therapy in the past, with no relief and medications. The current medications and physical therapy records were not included in the medical records provided for review. The medical report dated 10/27/2014 indicates that the injured worker remained symptomatic. The injured worker complained of pain in the lower back that radiated to the bilateral buttocks, tail bone, and legs. He rated the pain 3-4 out of 10. The pain was intermittent and became constant with activities. The injured worker still had numbness at times, weakness of the legs, sensation of pins and needles in the lower extremities, and difficulty walking as previous. An examination of the lumbar spine showed tenderness in the paralumbar area, more in the right than the left from L3-S1; mild spasm in the paralumbar area, more in the right than the left from L3-S1; tenderness in the interspinous area at L4-L5 and L5-S1; tenderness over the bilateral lower facet joints; tenderness on the bilateral greater sciatic notch areas; and painful range of motion, with limitation more on the right side. On 11/05/2014, Utilization Review (UR) denied the request for a lumbar facet block. The UR physician noted that there was limited documentation of the results for imaging and the diagnosis of facet-mediated pain was not supported by the presentation. The UR physician cited the ACOEM guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Facet Block: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

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. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti, 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). 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: 1. No more than one therapeutic intra-articular block is recommended. 2. 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). 4. No more than 2 joint levels may be blocked at any one time.5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. In this case, there is no documentation of facet mediated pain. There is no evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. MTUS guidelines do not recommend more than 2 joint levels to be blocked at any one time. Therefore, the request for lumbar facet block is not medically necessary.