

Case Number:	CM14-0210864		
Date Assigned:	12/23/2014	Date of Injury:	10/23/1980
Decision Date:	02/19/2015	UR Denial Date:	11/14/2014
Priority:	Standard	Application Received:	12/16/2014

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. 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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 58-year-old woman who sustained a work related injury on October 23, 1980. Subsequently, she developed chronic low back pain. the patient has been on opioid medications for an extended period of time. A request for the medial branch blocks for the right side at L2-3, L3-4, and L4-5 was denied on June 28, 2013. On July 3, 2013 the patient did have a medial branch blocks on the right at L3-4, L4-5, and L5-S1 with IV sedation and the use of steroids. The follow up from August 7, 2013 noted no change in the lumbar symptoms but a decrease in the pain from the right hip area. she continued to require opioid pain medications. According to a follow-up report dated December 2, 2014, the patient continued to complain of severe pain in her lower back and referred pain to her left hip region ans S1 nerve root distribution. She rated the level of her pain as a 7-8/10. She described her pain as sharp and shooting. Examination of the lumbar spine/thoracic spine revealed positive tenderness in the paralumbar musculature. Negative tenderness in the parathoracic musculature. Negative tenderness in the posterior superior iliac spine region. Negative tenderness in the SI joints. There was positive muscle spasming in the paralumbar musculature. Motor testing was 5/5 to all muscle groups of lower extremities. Walking on tiptoes was performed without difficulty. Walking on heels was performed without difficulty. Deep tendon reflexes were 2+. Range of motion was limited with forward flexion at 60 degrees, forward flexion at 60 degrees with pain, extension at 30 degrees, lateral tilt 30 degrees bilaterally, and bilateral rotation at 30 degrees. There was positive straight leg raise, right side diminished sensation. Examination of the left hip revealed positive tenderness over the greater trochanteric bursa. Negative pain with internal rotation. Motor testing

was 5/5. Negative Patricks test. Range of motion was limited by pain. The patient was diagnosed with degenerative disc disease of the lumbar spine, lumbar spine herniated disc, lumbar spine annular tear, radiculopathy (EMG confirmed/neuropathic pain), and let hip greater trochanteric bursitis. The provider requested authorization for Medial Branch Block bilaterally at L4, L5, S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial Branch Block bilaterally at L4, L5, S1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, the patient did have a medial branch blocks on the right at L3-4, L4-5, and L5-S1 with IV sedation and the use of steroids; however, there was no change in the lumbar symptoms. The patient has lumbar

radiculopathy (EMG confirmed). Therefore, the Medial Branch Block bilaterally at L4, L5, S1 is not medically necessary.