

Case Number:	CM15-0100133		
Date Assigned:	06/02/2015	Date of Injury:	11/30/2012
Decision Date:	06/30/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/26/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 58 year old male with an industrial injury dated 11/30/2012. His diagnoses included cervicalgia, low back pain and neurogenic bladder dysfunction. Prior treatments included-facet block injection (which did not provide significant relief), back surgery, physical therapy, chiropractic care and a TENS unit. He presents on 04/16/2015 with complaints of neck pain rated as 5-6/10 and lumbosacral pain rated as 4-5/10. He also notes some intermittent leg pain when he is standing for prolonged periods of time. He complains of numbness and tingling in his right leg. He had been taking Naprosyn but states he did not notice any pain relief. He had not started the gabapentin due to concern about side effects and had also not started to use the cyclobenzaprine ointment. Physical exam noted exacerbation of lumbar pain with extension and rotation, Muscle spasms and guarding were present. Motor strength and gait were normal. He has diminished left bicep reflex, absent triceps reflex and absent bilateral gastrocnemius reflex. The provider noted there were no objective signs of radiculopathy or myelopathy on the exam. The injured worker wished to attempt a facet block. The provider recommended performing a cervical 5-6 and cervical 6-7 facet blocks via medial branch blocks. For the lumbar spine a facet block via medial branch block was recommended. They provider notes the injured worker is awaiting a urology consultation for his bladder dysfunction. Opioid treatment agreement was completed on 03/05/2015. The provider recommended discontinuing Naprosyn as it was not effective. He was encouraged to go ahead and take the Gabapentin and to use cyclobenzaprine ointment. This request is for bilateral cervical 5 - cervical 6 and cervical 6 - cervical 7 medial branch blocks and bilateral lumbar medial branch block at lumbar 4-5 and lumbar 5 - sacral 1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Cervical Medial Branch Block at C5-C6 and C6-7: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter, Facet Joint Therapeutic steroid injections.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, facet and medical branch blocks.

Decision rationale: The ACOEM states: 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. Per the ODG, facet joint injections are under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are currently not recommended as a treatment modality in most evidence based reviews as their benefit remains controversial. Criteria for use of diagnostic blocks for facet nerve pain: 1. One set of diagnostic medial branch blocks is required with a response of 70% 2. Limited to non-radicular cervical pain and no more than 2 levels bilaterally. 3. Documentation of failure of conservative therapy 4. No more than 2 joint levels are injected in 1 session 5. Diagnostic facet blocks should be performed in patients whom a surgical procedure is anticipated The requested service is not recommended per the ACOEM or the Official Disability Guidelines. Criteria cited above have not been met in the clinical documentation and therefore the request is not medically necessary.

Bilateral Lumbar Medial Branch Block at L4-5, L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar and Thoracic, Facet Joint Injections.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, facet and medial branch blocks.

Decision rationale: The ACOEM states: 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. Per the ODG, facet joint injections are under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. Intra-

articular facet joint injections have been popularly utilized as a therapeutic procedure, but are currently not recommended as a treatment modality in most evidence based reviews as their benefit remains controversial. Criteria for use of diagnostic blocks for facet nerve pain: 1. One set of diagnostic medial branch blocks is required with a response of 70% 2. Limited to non-radicular cervical pain and no more than 2 levels bilaterally. 3. Documentation of failure of conservative therapy 4. No more than 2 joint levels are injected in 1 session. 5. Diagnostic facet blocks should be performed in patients whom a surgical procedure is anticipated. The requested service is not recommended per the ACOEM or the Official Disability Guidelines. Criteria cited above have not been met in the clinical documentation and therefore the request is not medically necessary.