

Case Number:	CM15-0102802		
Date Assigned:	06/05/2015	Date of Injury:	06/30/2002
Decision Date:	07/10/2015	UR Denial Date:	05/07/2015
Priority:	Standard	Application Received:	05/28/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 50 year old male, who sustained an industrial injury on June 30, 2002 while working as a project controller. The injured worker gradually developed low back pain. The diagnoses have included lumbar disc disease with bulging, lumbar radiculitis, lumbar facet arthropathy and failed back surgery syndrome. Treatment to date has included medications, radiological studies, MRI, electrodiagnostic studies, pain management consultation and lumbar spine surgery. Current documentation dated April 16, 2015 notes that the injured worker reported constant low back pain with radiation to the left lower extremity to the level of the knee. The pain was rated an eight out of ten on the visual analogue scale. Examination of the lumbar spine revealed pain, spasms and a decreased range of motion. Facet loading was noted to be positive on the left. Patrick's test was positive, more on the left. A straight leg raise was negative. The treating physician's plan of care included a request for left lumbar diagnostic facet blocks under C-arm fluoroscopic guidance to lumbar four-lumbar five and lumbar five-sacral one.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left lumbar diagnostic facet block under C-arm fluoroscopic guidance L4-L5, L5-S1:
Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), chapter low back-lumbar and thoracic (acute and chronic) facet joint diagnostic blocks (injections).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 309. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Facet Injections (Diagnostic).

Decision rationale: Regarding the request for lumbar medial branch blocks, the CA MTUS references ACOEM Chapter 12, which specify invasive techniques such as facet blocks are of questionable merit. These injections may be appropriate in the transitional phase from acute to chronic pain. More specific recommendations as found in the ODG as cited below: "Criteria for the use of diagnostic blocks for facet 'mediated' pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a 'sedative' during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)]" In the case of this injured worker, there is documentation of concomitant radicular symptomatology. Given this, this request is medically necessary. In this case, there is long standing low back pain. Electrodiagnostic studies failed to demonstrate lumbar radiculopathy. Although there are disc bulges noted at multiple lumbar levels on MRI, the patient's pain is mostly axial in nature. This is one of criteria set by the ODG in order to have diagnostic facet injections. Tenderness to the lumbar facets is noted on exam on March 14, 2015. Given this clinical picture, these injections are medically necessary.