

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0014032 | | |
| Date Assigned: | 02/02/2015 | Date of Injury: | 02/01/2008 |
| Decision Date: | 03/25/2015 | UR Denial Date: | 01/16/2015 |
| Priority: | Standard | Application Received: | 01/24/2015 |

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: 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 injured worker is a 46 year old female who sustained a work related injury on February 1, 2008, and suffered a punch in the eye, injured shoulder and low back injuries after being thrown by another person. Treatments included rest, activity modification, Non-Steroidal Anti-Inflammatory Drugs, physical therapy and pain medications. Diagnoses included lumbar disc disorder, sprain of sacroiliac and lumbosacral spondylosis without myelopathy. Currently on January 6, 2015, the injured worker presented with complaints of chronic intractable low back pain with radiation into her sacroiliac joints. On January 15, 2015, a request for services of a bilateral medial branch block of the lumbar sacral spine (L4-5 and L5-S1) was non-certified by Utilization Review, noting the American College of Occupational and Environmental Medicine occupational Medicine Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral medial branch block L4-L5: 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, there is no documentation of facet mediated pain; There is no clear evidence or documentation that lumbar and sacral facets are main pain generator. The patient has had bilateral radiofrequency lesioning at L4-5 and L5-S1, performed on October and November of 2013. Therefore, the request for Medial Branch block Targeting Bilateral L4-5, L5-S1 is not medically necessary.

Bilateral medial branch block at 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, there is no documentation of facet mediated pain; There is no clear evidence or documentation that lumbar and sacral facets are main pain generator. The patient has had bilateral radiofrequency lesioning at L4-5 and L5-S1, performed on October and November of 2013. Therefore, the request for Medial Branch block Targeting Bilateral L4-5, L5-S1 is not medically necessary.