

Case Number:	CM15-0110075		
Date Assigned:	06/16/2015	Date of Injury:	02/15/2007
Decision Date:	07/16/2015	UR Denial Date:	05/27/2015
Priority:	Standard	Application Received:	06/08/2015

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 53 year old female, who sustained an industrial injury on 02/15/2007. The injured worker is currently permanent and stationary. The injured worker is currently diagnosed as having multilevel disc herniations of cervical spine with moderate to severe neural foraminal narrowing and lumbar disc herniations at L3-L4, L4-L5, and L5-S1 with mild to moderate neural foraminal narrowing. Treatment and diagnostics to date has included 15 to 20 visits of physical therapy that did not help, 24 visits of chiropractic treatment with good relief, 5 visits of acupuncture with no relief, cervical epidural steroid injection with 90% relief for over a year, and medications. In a progress note dated 05/07/2015, the injured worker presented with complaints of neck and low back pain. Objective findings include an antalgic gait and tenderness to palpation to the cervical and lumbar spine. The treating physician reported requesting authorization for bilateral lumbar medial branch block.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral medial branch block at L4-L5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Facet joint diagnostic blocks, Facet joint medial branch blocks.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 300, 309.

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, the patient has had a previous medial branch block on 1/17/2014 without significant relief. Typically, medial branch block are not meant to be repeated, and only if significant relief is documented, then follow up with radiofrequency ablation treatments are indicated. In this case, a repeat bilateral medial branch block is not medically necessary.