

Case Number:	CM15-0112765		
Date Assigned:	06/19/2015	Date of Injury:	09/24/2013
Decision Date:	07/17/2015	UR Denial Date:	06/01/2015
Priority:	Standard	Application Received:	06/11/2015

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: Arizona, California
 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 23 year old male, who sustained an industrial injury on 9/24/13. He has reported initial complaints of low back injury with pain. The diagnoses have included lumbar spondylosis and herniated lumbar disc without myelopathy. Treatment to date has included medications, activity modifications, epidural steroid injection (ESI), physical therapy, trigger point injections, facet injection, medial branch block, and other modalities. Currently, as per the physician progress note dated 5/18/15, the injured worker complains of low back pain that goes into the left buttocks. The pain is described as numbness with pins and needles that radiates to the left leg. The pain is unchanged from the previous visit. The objective findings reveal decreased lumbar range of motion due to pain, straight leg raise causes back pain, and there is positive Patrick test and reverse Thomas test noted. There is tenderness noted over the left and right lumbar facet joints worsened with extension and rotation. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the lumbar spine dated 10/31/13 reveals multi-level hypertrophic changes, disc protrusion with narrowing of the canal, and bilateral lateral recess stenosis due to discopathy. There is also an electromyography (EMG) and NBCV of the bilateral lower extremities. The current medications included Norco, Gabapentin, Vicodin and Nortriptyline. The previous therapy sessions were not noted. The physician requested treatment included bilateral lumbar L3, L4, and L5 MBB #2.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral lumbar L3, L4, L5 MBB #2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back & Lumbar & Thoracic, Facet joint diagnostic blocks (injections).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- Low back pain - lumbar MBB and pg 36.

Decision rationale: According to the guidelines, Criteria for the use of diagnostic blocks for facet "mediated" pain: Clinical presentation should be consistent with facet joint pain, signs and symptoms. 1. One set of diagnostic medial branch blocks is required with a response of $\geq 70\%$. 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. According to the ACOEM guidelines, invasive procedures are not recommended due to short-term benefit. In this case, the claimant had prio ESI that provided 60% pain relief for only 1 week. In addition, the exam findings and prior imaging (on 10/31/14) are not clear on L3-L4 radiculopathy. The request for an additional MBB is not medically necessary.