

Case Number:	CM15-0114395		
Date Assigned:	06/22/2015	Date of Injury:	09/19/2013
Decision Date:	07/27/2015	UR Denial Date:	05/20/2015
Priority:	Standard	Application Received:	06/15/2015

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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 09/19/2013. He has reported injury to the low back. The diagnoses have included bilateral lumbar radiculitis; lumbar degenerative disc disease; neural foraminal narrowing at L5-S1 bilaterally; and lumbar spondylolisthesis of L5 on S1. Treatment to date has included medications, diagnostics, physical therapy, and home exercise program. Medications have included Ibuprofen and Gabapentin. A progress note from the treating physician, dated 05/04/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of continued lumbar axial pain across the lumbosacral junction region, which is present with prolonged standing or extension maneuvers; the Gabapentin did not help with those symptoms; since his last visit, he had run out of Gabapentin and has had return of the bilateral lower limb radicular symptoms which had improved after taking Gabapentin; and he has been performing a home exercise program on a regular basis. Objective findings included lumbar spine range of motion extension and extension rotation maneuvers provoke lumbar axial pain bilaterally at end range of motion. The treatment plan has included the request for bilateral L5-S1 medial branch block/facet joint injection x 2.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L5-S1 medial branch block/facet joint injection x 2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, facet joint diagnostic blocks.

Decision rationale: MTUS is silent concerning cervical medical branch blocks. ODG recommends "Criteria for the use of diagnostic blocks for facet nerve 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 be approximately 2 hours for Lidocaine. 2. Limited to patients with cervical 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 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, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy. 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 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. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. 12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment." The treating physician's request for Bilateral L5-S1 medial branch block/facet joint injection x 2 do not indicate a failure of conservative treatment (including home exercise, PT and NSAIDs). In fact the progress note state that the patient had 50% improvement with gabapentin. There is also evidence of radiculopathy which the blocks are not indicated for. As such the request for Bilateral L5-S1 medial branch block/facet joint injection x 2 is not medically necessary.