

Case Number:	CM15-0119023		
Date Assigned:	06/29/2015	Date of Injury:	06/16/1969
Decision Date:	07/28/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/19/2015

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, Alabama, 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 (IW) is a 68-year-old male who sustained an industrial injury on 06/16/1969. Diagnoses include bilateral lumbar facet joint pain at L4-5 and L5-S1; lumbar sprain/strain; chronic low back pain; status post positive diagnostic bilateral facet joint medial branch nerve blocks at L4-5 and L5-S1. Treatment to date has included medications, medial branch nerve blocks, chiropractic treatment and physical therapy. According to the progress notes dated 5/13/15, the IW reported bilateral low back pain radiating into the buttocks; left neck pain and left shoulder pain. He confirmed the bilateral L4-5 and L5-S1 medial branch nerve blocks performed on 4/30/15 provided 100% pain relief and increased range of motion for greater than two hours. On examination, range of motion of the lumbar spine was restricted in all planes; lumbar extension was worse than flexion. The paraspinal muscles over the L4-5 and L5-S1 facet joints were tender to palpation and lumbar discogenic provocative maneuvers were negative bilaterally. Sensation and motor strength testing was within normal limits. Medications listed did not include pain medication. A request was made for fluoroscopically-guided bilateral L4-L5 and bilateral L5-S1 facet joint radiofrequency nerve ablations to more permanently treat the facet pain at those levels.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluoroscopically guided bilateral L4-L5 and bilateral L5-S1 facet joint radiofrequency nerve ablation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-1.

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. The ODG guidelines did not support facet injection for lumbar pain in this clinical context. There is no documentation of facet mediated pain or that facets are the main pain generator. There is no documentation of failure of conservative therapies in this patient. Therefore, the request for fluoroscopically guided bilateral L4-L5 and bilateral L5-S1 facet joint radiofrequency nerve ablation is not medically necessary.