

Case Number:	CM15-0127051		
Date Assigned:	07/13/2015	Date of Injury:	08/01/2012
Decision Date:	08/10/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	07/01/2015

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 is a 57 year old male who sustained an industrial injury on 08/01/2012. Mechanism of injury occurred when he fell out of truck installing components in a dashboard, falling about 5 feet. Diagnoses include lumbo/lumbosacral disc degeneration, lumbago, left radiculitis, and spondylosis without myelopathy of the lumbar region, shoulder joint pain, and hypertension. Treatment to date has included diagnostic studies, two right shoulder surgeries, medications, physical therapy, and transforaminal epidural injection. A Magnetic Resonance Imaging of the lumbar spine done on 12/22/2014 revealed impingement of bilateral L5 and S1 as well as degenerative disc disease and facet arthropathy. On 04/18/2015, a Magnetic Resonance Imaging of the cervical spine revealed anterior cervical fixation and solid interbody fusion at C5-6, degenerative joint disease at C2-3 through C6-7, and there are minimal bulging discs at C3-4, C4-5 and C6-7, which are not contacting the underlying spinal cord, mild neural foraminal narrowing at C3-4 on the right and left. An Electromyography and Nerve Conduction Velocity done on 03/13/2015 revealed moderate tibial nerve compromise at or near the ankle bilaterally with demyelinating and axonopathy, and mild median nerve compromise at or near the wrist bilaterally, involving sensory fibers only with demyelination and no acute evidence of axonopathy at this time. A Magnetic Resonance Imaging of the right shoulder done on 04/08/2015 showed status post rotator cuff repair and an acromioplasty and biceps tendon tenodesis, there is residual partial tear at the lateral edge of the infraspinatus tendon and a small new intrasubstance longitudinal split tear at the infraspinatus tendon, and small amount of fluid or inflammation in the subdeltoid bursa. His medications include Amlodipine and Norco. A

physician progress note dated 05/15/2015 documents the injured worker has back pain with his average pain level is 9 out of 10, without medications his pain is 9 out of 10 and with medications his pain is rated 8 out of 10. He walks with a limp. There is tenderness to the paraspinous, right S1 joint, and right buttock, and mild muscle spasms are present. Passive range of motion is restricted, and painful. There are positive piriformis maneuvers, right greater than the left. He has right sided back pain with radiation to the right lateral thigh and lateral foot, likely secondary to radiculitis. Differential diagnoses likely facet arthropathy versus S1 dysfunction. He is status post 2 shoulder surgeries with continued limited range of motion and weakness, currently is followed with an orthopedic surgeon. Treatment requested is for outpatient right L3-5 medial branch block.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient right L3-5 medial branch block: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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 that the lumbar facets are the main pain generator. There is no clear documentation of failure of physical therapy and pain medications. Therefore, the Left lumbar medial branch block L4-5 is not medically necessary.