

Case Number:	CM15-0171621		
Date Assigned:	09/11/2015	Date of Injury:	05/05/2015
Decision Date:	10/19/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	08/31/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, 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 40 year old female, who sustained an industrial injury on 5-5-2015. The current diagnoses are lumbago, back disorder (not otherwise specified), spasm of muscle, and sacroiliitis. According to the progress report dated 7-28-2015, the injured worker complains of moderate-to-severe low back pain. She describes the pain as dull, aching pain with an occasional sharp component over the left lower back. She notes that physical therapy has not provided her with much relief and medications at best are providing her with very modest pain relief. She has difficulty sleeping at night and has insomnia. The level of pain is not rated. The physical examination of the lumbar spine reveals paravertebral muscle spasms, tenderness and tight muscle band bilaterally, loss of normal lordosis, 3 out of 5 core conditioning and strength, restricted and painful range of motion, and positive Faber's test. The current medications are Cyclobenzaprine and Ibuprofen. Treatment to date has included medication management, x-rays, physical therapy, home exercise program, and MRI studies. Per the PR-2 on 8-11-2015 the MRI scan shows "degenerative disease L5-S1 with broad-based disc bulge. No central canal or lateral recess stenosis. Mild bilateral foraminal narrowing. There is a small amount of fluid-edema involving the left aspect of the L5-S1 intervertebral disc which may represent acute inflammation." Work status is described as working with restrictions of 7 hours a day. The original utilization review (8-26-2015) had non-certified a request for left S1 joint block (S1-S3 lateral branch block) under fluoroscopy and L5-S1 Medial branch block under fluoroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left S1 joint block (S1-S3 lateral branch block) under fluoroscopy Qty 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip & Pelvis - Sacroiliac injections, diagnostic.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, Sacroiliac injections.

Decision rationale: Per the ODG guidelines with regard to sacroiliac joint injections: Not recommended, including sacroiliac intra-articular joint and sacroiliac complex diagnostic injections/blocks (for example, in anticipation of radiofrequency neurotomy). Diagnostic intra-articular injections are not recommended (a change as of August 2015) as there is no further definitive treatment that can be recommended based on any diagnostic information potentially rendered (as sacroiliac therapeutic intra-articular injections are not recommended for non-inflammatory pathology). Consideration can be made if the injection is required for one of the generally recommended indications for sacroiliac fusion. See Sacroiliac fusion. Also not recommended: Sacral lateral branch nerve blocks and/ or dorsal rami blocks in anticipation of sacroiliac radiofrequency neurotomy. See Diagnostic blocks in anticipation of SI neurotomy below. As the requested treatment is not recommended by the guidelines, it is not medically necessary.

L5-S1 Medial branch block under fluoroscopy Qty 1: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

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

Decision rationale: Per the ODG guidelines, facet joint medial branch blocks are not recommended except as a diagnostic tool, citing minimal evidence for treatment. The ODG indicates that criteria for facet joint diagnostic blocks (injections) are as follows: 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)] I respectfully disagree with the UR physician's denial based upon a lack of failure of 4-6 weeks of conservative therapy. Per the medical records, the date of injury was 5/5/15, per progress report dated 8/4/15 the injured worker reported a continued lack of relief from medication and physical therapy. The request is medically necessary.