

Case Number:	CM15-0179106		
Date Assigned:	09/21/2015	Date of Injury:	07/05/2011
Decision Date:	10/23/2015	UR Denial Date:	08/29/2015
Priority:	Standard	Application Received:	09/11/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 55 year old male who sustained an industrial injury on 7-5-11. A review of the medical records indicates he is undergoing treatment for lumbosacral spondylosis without myelopathy and lumbar facet syndrome. Medical records (4-8-15 to 8-13-15) indicate ongoing complaints of low back pain, radiating to his left lower extremity. He reports decreased range of motion, limited activities, and increased stiffness. He has rated his pain 4-6 out of 10, with the most recent rating at 5 out of 10. He reports that his pain is located in the lumbar area and upper buttock. He describes it as "aching". The physical exam reveals lumbar flexion at 60 degrees limited by pain, lumbar extension at 10 degrees limited by pain, and tenderness to palpation of the lumbar paravertebrals L4 and L5 facet joints. Diagnostic studies have included x-rays of the chest, pelvis, and right knee, and MRI of the lumbar spine, and CT scans of the brain, cervical spine, and chest. Treatment has included oral and transdermal medications, a TENS unit, physical therapy, modified work activities, a back brace, 12 psychological visits, and bilateral L4-5 and L5-S1 facet joint injections. The facet joint injections provided 70% improvement on the left side and 80% improvement on the right side. These were administered on 5-21-15 and by the 8-13-15 visit, the provider noted that he was back to "pre-injection pain levels along with decreased range of motion, limited activities, and increased stiffness". The request for treatment is lumbar medial branch block of L4-5 and L5-S1 facet joints. The utilization review (8-29-15) indicates denial of the request, stating that the procedure is not medically necessary, as there is no documentation that if the blocks were successful, that the treatment "may proceed to facet neurotomy at the diagnosed levels".

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial branch block for bilateral lumbar spine L3, L4, L5: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. 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-Lumbar & Thoracic (Acute & Chronic), Lumbar Diagnostic facet joint blocks (injections).

Decision rationale: The claimant sustained a work injury in July 2011 and is being treated for chronic low back pain. He underwent bilateral intra-articular facet injection at L4/5 and L5/S1 on 05/21/15. Immediately afterwards he had decreased pain from 6/10 to 2/10. When seen in August 2015, there had been 70% improvement with improved activity tolerance and decreased medication use and had been able to discontinue Norco but had restarted his medications as his pain had returned to pre-injection levels. Physical examination findings included decreased and painful lumbar range of motion with positive facet tenderness. A diagnostic medial branch block procedure is being requested. Although the use of a confirmatory block is not currently being recommended, the rationale for this is related to cost. However, given the high cost of medial branch radiofrequency ablation, known rate of false positive diagnostic blocks, and the neuro destructive nature of the ablation procedure, if requested, a confirmatory block procedure should be considered for coverage. Performing an unnecessary radiofrequency ablation treatment not only places the individual at increased risk for nerve injury but also could potentially lead to unnecessary and costly repeat procedures. In this case, the claimant's response to the injection done with xylocaine and Kenalog is equivocal with decreased pain of less than 70% immediately after the procedure but with sustained improvement afterwards. Physical examination findings support the procedure being requested and a pain diary is being used to document the results of the procedure. The requested diagnostic only medial branch block procedure is both appropriate and medically necessary.