

Case Number:	CM15-0039848		
Date Assigned:	03/10/2015	Date of Injury:	06/10/2008
Decision Date:	04/20/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/03/2015

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, Michigan, 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 44 year old female, who sustained a work related injury on 6/10/08. She was involved in a motor vehicle accident and was hit head on. The diagnoses have included lumbosacral facet arthropathy and myofascial pain syndrome. Treatments to date have included medications, activity modification and rest. In the office visit note dated 2/12/15, the injured worker complains of low back pain that radiates to both buttocks and both thighs. She describes the pain as constant, sharp and throbbing. She states pain is better at rest and made worse by activity. She has limited range of motion. She has tenderness upon palpation of lumbar area with trigger points and facet joints on both sides at L4-S1 levels. The treatment plan is to request medial branch blocks that may be helpful as well as therapy. A lumbar spine MRI was ordered.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluoroscopic guidance for medial branch block (MBB): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, Facet Joint Radiofrequency Neurotomy, page 36.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 303; 309.

Decision rationale: Since the Lumbar medial branch blocks bilateral L3, L4, L5 is not medically necessary, the Fluoroscopic guidance for medial branch block is not certified.

Lumbar medial branch blocks bilateral L3, L4, L5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, Facet Joint Radiofrequency Neurotomy, page 36.

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 of facet mediated pain; although the patient has positive facet loading bilaterally, there is no clear and recent documentation that the facets are the main pain generator. There is no clear documentation that the patient failed conservative therapies. Furthermore, the guidelines do

not recommend more than 2 levels at the same time. Therefore, the request for Lumbar medial branch blocks bilateral L3, L4, L5 is not medically necessary.

Magnetic resonance imaging (MRI) of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: Regarding the indications for imaging in case of back pain, MTUS guidelines stated: Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Furthermore, and according to MTUS guidelines, MRI is the test of choice for patients with prior back surgery, fracture or tumors that may require surgery. The patient does not have any clear evidence of new lumbar nerve root compromise. There is no clear evidence of significant change in the patient signs or symptoms suggestive of new pathology. Therefore, the request for lumbar MRI is not medically necessary.