MAXIMUS Federal Services

Case Number:	CM15-0076502		
Date Assigned:	04/28/2015	Date of Injury:	04/02/2014
Decision Date:	06/05/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	04/21/2015

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: Montana
Certification(s)/Specialty: Preventive Medicine, Occupational 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 48 year old female, who sustained an industrial injury on 4/2/14 when her bus was hit by another vehicle. The injured worker has complaints of bilateral axial low back pain with mild, left greater than right lower extremity radicular pain. The diagnoses have included disk protrusion at L4-5; left leg radiculopathy; degenerative disc disease and lumbar and thoracic strain, and lumbago. Treatment to date has included status post right T12-L1 epidural injection with no significant improvement in her pain; lumbar intra-articular facet injections with some improvement, tramadol, Norco; Celebrex and Hysingla. The request was for outpatient diagnostic facet-medical branch blocks of the left L4-5 and left L5-S1 facet joints.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient diagnostic facet-medical branch blocks of the left L4-5 and left L5-S1 facet joints: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation, 2015 web-based edition.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Facet joint diagnostic blocks (injections) and Facet joint injections multiple series.

Decision rationale: The MTUS, in the ACOEM guidelines, notes that 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. The ODG Guidelines note that diagnostic facet injections are recommend, with no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered under study). Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. (Cohen, 2007) (Bogduk, 2000) (Cohen2, 2007) (Mancchukonda, 2007) (Dreyfuss, 2000) (Manchikanti2, 2003) (Datta, 2009) Criteria for the use of diagnostic blocks for facet mediated pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 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. 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)] The ODG guidelines note that facet joint injections in multiple series are not recommended. Diagnostic blocks: One set of medial branch blocks is recommended prior to a neurotomy. Intra-articular blocks are not recommended as the diagnostic procedure.

Confirmatory blocks, while recommended for research studie s, do not appear to be cost effective or to prevent the incidence of a false positive response to the neurotomy procedure itself. See Facet joint diagnostic blocks (injections). Therapeutic injections: With respect to facet joint intra-articular therapeutic injections, 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). See Facet joint intra-articular injections (therapeutic blocks). There is no peer-reviewed literature to support a series of therapeutic fact blocks. In this case the initial injections were intra-articular injections with some benefit however, the percentage of pain relief is not noted. The current request is for diagnostic medial branch blocks for the left L4-5 and L5-S1 facet levels. If effective, radiofrequency ablation might prevent surgery. The injured worker's symptoms are primarily axial and clinically they appear to be facet mediated. The criteria for medial branch blocks is met. The request for diagnostic left medial branch blocks at L4-5 and L5-S1 is consistent with the published guidelines/criteria and is medically necessary.