

Case Number:	CM15-0089807		
Date Assigned:	05/14/2015	Date of Injury:	08/13/1992
Decision Date:	10/13/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/11/2015

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: California

Certification(s)/Specialty: Family Practice

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 58 year old female who sustained an industrial injury on 08-13-1992. Current diagnoses include lumbago, and thoracic or lumbosacral neuritis or radiculitis. Report dated 03-24-2015 noted that the injured worker presented with complaints that included chronic mid and low back pain, left worse than right. The pain is constant to her low back which radiates down her left leg and has tingling in her left ankle with occasional radiation down her right leg. Pain level was 7 (present), 10 (without medication), 4 (with medication), and 5 (average) out of 10 on a visual analog scale (VAS). The injured worker stated that she had a procedure done in the past that "killed the nerve" and this helped with the radiuclar pain. The injured worker had previous back surgery. Physical examination was positive for restricted range of motion, tenderness in the cervical spine, and tenderness over the lower paraspinal muscles bilaterally. Pain is improved with medications, heating pad, stretches, and hot tub. The treatment plan included request for a diagnostic medial branch block for possible radio frequency ablation, request for an updated MRI, prescribed Norco for pain, continue ibuprofen and Tylenol, warm compresses over the painful site, and do regular home exercises as directed. The injured worker has not worked since November of 1993. Request for authorization dated 03-24-2015, included requests for diagnostic medial branch block for possible radio frequency ablation. The utilization review dated 04-21-2015, non-certified the request for diagnostic medial branch block for possible radio frequency ablation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic Medial Nerve Branch Block, possible radiofrequency ablation: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Lumbar & Thoracic (acute & chronic) - Facet joint diagnostic blocks.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Low Back Complaints, Section: Facet Joint/Diagnostic Blocks.

Decision rationale: The Official Disability Guidelines comment on the use of diagnostic medial nerve branch blocks. These guidelines state the following: Recommend 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. MBB procedure: The technique for medial branch blocks in the lumbar region requires a block of 2 medial branch nerves (MBN). The recommendation is the following: (1) L1-L2 (T12 and L1 MBN); (2) L2-L3 (L1 and L2 MBN); (3) L3-L4 (L2 and L3 MBN); (4) L4-L5 (L3 and L4 MBN); (5) L5-S1: the L4 and L5 MBN are blocked, and it is recommended that S1 nerve be blocked at the superior articular process. Blocking two joints such as L3-4 and L4-5 will require blocks of three nerves (L2, L3 and L4). Blocking L4-5 and L5-S1 will require blocks of L3, L4, L5 with the option of blocking S1. The volume of injectate for diagnostic medial branch blocks must be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate), as increased volume may anesthetize other potential areas of pain generation and confound the ability of the block to accurately diagnose facet pathology. Specifically, the concern is that the lateral and intermediate branches will be blocked; nerves that innervate the paraspinal muscles and fascia, ligaments, sacroiliac joints and skin. Intraarticular blocks also have limitations due to the fact that they can be technically challenging, and if the joint capsule ruptures, injectate may diffuse to the epidural space, intervertebral foramen, ligamentum flavum and paraspinal musculature. A recent meta-analysis concluded that there is insufficient evidence to evaluate validity or utility of diagnostic selective nerve root block, intra-articular facet joint block, medial branch block, or sacroiliac joint block as diagnostic procedures for low back pain with or without radiculopathy. This study suggests that proceeding to radiofrequency denervation without a diagnostic block is the most cost-effective treatment paradigm, but does not result in the best pain outcomes. 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 (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. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. In this case, the records do not provide sufficient clarity as to the location of the injection and whether the patient meets the above cited ODG criteria for a diagnostic medial nerve branch block. It is unclear whether the patient has signs and symptoms of facet joint pain. Again, there is no specific treatment site identified in the request. Finally, it is unclear that the patient has received an adequate course of conservative treatment. For these reasons, a diagnostic medial nerve branch block with possible radiofrequency ablation is not medically necessary at this time.