

Case Number:	CM15-0093995		
Date Assigned:	05/20/2015	Date of Injury:	02/01/2012
Decision Date:	06/19/2015	UR Denial Date:	04/15/2015
Priority:	Standard	Application Received:	05/15/2015

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, Alabama, 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 37-year-old male who sustained a work related injury February 1, 2012. While on a ladder changing a light bulb, he lost his balance and fell approximately five feet down onto the ground, landing on his back. He had complaints of low back, left knee, left ankle, and left thumb pain. He was treated for approximately three months with medication, physical therapy, and x-rays. An MRI of the left knee revealed a meniscal tear and on July 9, 2013, he underwent a left knee medial meniscectomy. The pain in the left knee became worse and an MR Arthrogram showed the tear still present. An interventional pain management follow-up evaluation report, dated March 12, 2015, finds the injured worker with complaints of lumbar spine and left knee pain, rated 8/10. He is currently in physical therapy, which provides relief. There is evidence of tenderness on palpation of the facet joints and increased pain on extension and lateral bending. Diagnoses are lumbar spine discopathy; left knee internal derangement; left ankle sprain/strain. Treatment plan included a request for authorization for bilateral L4-5, L5-S1 medial branch blocks and Fexmid.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fexmid 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41.

Decision rationale: According to MTUS guidelines, a non-sedating muscle relaxant is recommended with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient in this case does not have clear evidence of acute exacerbation of the pain and spasm and the prolonged use of Fexmid 7.5mg is not justified. Therefore, the request is not medically necessary.

Bilateral L4-L5 Medial Branch Blocks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Guidelines, Low Back, Facet Joint Medical Branch Blocks (therapeutic injections); Pain Physician, 2005.

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

Decision rationale: According ACOEM Practice 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 the ODG, facets injections are 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. 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, according to the ODG 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 clear evidence that lumbar facets are the main pain generator. The diagnosis of radiculopathy or spinal stenosis was not fully excluded in this case. Therefore, the request is not medically necessary.

Bilateral L5-S1 Medial Branch Blocks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Guidelines, Low Back, Facet Joint Medical Branch Blocks (therapeutic injections); Pain Physician, 2005.

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

Decision rationale: According ACOEM Practice 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 the ODG, facets injections are 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. 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, according to the ODG 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 clear evidence that lumbar facets are the main pain generator. The diagnosis of radiculopathy or spinal stenosis was not fully excluded in this case. Therefore, the request is not medically necessary.