

Case Number:	CM13-0027129		
Date Assigned:	06/06/2014	Date of Injury:	03/31/2002
Decision Date:	07/24/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	09/20/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 63-year-old male with a reported date of injury on 03/31/2002. The mechanism of injury was not submitted within the medical records. His diagnoses were noted to include cervical disc degenerative, myalgia and myositis, idiopathic torsion dystonia, arthrodesis status, internal derangement of the knee, cervical spinal stenosis, lumbosacral spondylosis, lumbosacral disc degenerative, and lumbosacral neuritis. His previous treatments were noted to include a daily gym program, medications, and C8 epidural steroid injections. The provider reported lumbar x-rays taken on 09/29/2010 revealed L3-4 degenerative disc disease with retrolisthesis and L4-5 and L5-S1 facet arthropathy. The progress note dated 04/22/2014 reported the injured worker complained of bilateral neck pain, tightness, bilateral pectoral pain, and right low back pain. The injured worker reported he was 60% better after the C8 epidural steroid injection and was doing more around the house. The injured worker reported he could not walk well due to low back pain and his medication helped some but his knee occasionally gave out. The injured worker rated his average pain as 2/10. The physical examination revealed diminished range of motion to the cervical spine and palpation was tender to C4-5, C6-7, facet joints with paraspinal trigger points, right greater than left. The physical examination of the lumbar spine revealed mild tender right L4-5, L5-S1 space-facet joints, and trigger points in the gluteals, as well as a reduced range of motion. Special testing to the lumbar spine was noted to be facet joint/neural foraminal loading which was positive on the right. The neurological examination noted bilateral weakness to manual muscle testing and sensory examination was reduced to the right lateral thigh to pinprick and light touch, and the reflexes were symmetrical. The straight leg raise test was negative. The request for authorization form dated 09/03/2013 is for a right L3-4, L4-5, L5-S1 facet injection under fluoroscopy. However, the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

FACET INJECTION RIGHT L3-4, L5-S1 UNDER FLUOROSCOPY, QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

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, Facet joint diagnostic blocks.

Decision rationale: The request for a facet injection to the right L3-4 and L5-S1 under fluoroscopy is not medically necessary. The injured worker has had a previous lumbar epidural steroid injection due to lumbar radiculopathy. The Official Disability Guidelines recommend no more than 1 set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment. The diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to a facet neurotomy at the diagnosed levels. The guidelines' criteria for the use of diagnostic blocks for facet-mediated pain is clinical presentation should be consistent with facet joint pain signs and symptoms such as tenderness to palpation on the paravertebral areas over the facet region, a normal sensory examination, absence of radicular findings, although pain may radiate below the knee, and a normal straight leg raising exam. The criteria also state 1 set of diagnostic medial branch blocks is required with a response of greater than 70%, its limited to patients with low back pain that is nonradicular and at no more than 2 levels bilaterally. There must be documentation of failure of conservative care including home exercise, physical therapy and NSAIDs prior to the procedure for at least 4 to 6 weeks. No more than 2 facet joint levels are injected in 1 session. The documentation provided indicated the injured worker has had a previous lumbar epidural steroid injection due to lumbar radiculopathy. Additionally, the injured worker has a diagnosis of lumbosacral neuritis. The injured worker was noted to have reduced sensory to the right lateral thigh to pinprick and light touch and weakness in motor strength which is consistent with radiculopathy, although he had positive facet joint and neural foraminal loading testing. Therefore, the request is not medically necessary.