

Case Number:	CM13-0029229		
Date Assigned:	09/08/2014	Date of Injury:	12/17/2003
Decision Date:	10/09/2014	UR Denial Date:	08/26/2013
Priority:	Standard	Application Received:	09/25/2013

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 Internal Medicine, has a subspecialty in Pulmonary Diseases 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 53-year-old female who reported an injury on 12/17/2003 due to an unknown mechanism. Diagnoses were status post work related injury, status post lumbar epidural steroid injection, chronic low back pain, and chronic neck pain. Past treatments were physical therapy, chiropractic therapy, acupuncture, aqua therapy, TENS unit, lumbar epidural steroid injections on 04/16/2012, 10/29/2012, and 06/10/2013. Diagnostic studies were MRI of the lumbar spine on 04/07/2007. The MRI revealed small posterior bulges of the L4-5 and the L5-S1 disc, degeneration of the L4-5 and the L5-S1 disc, no central canal or neural foraminal stenosis, no significant interval change since 07/14/2005. Surgical history was left shoulder arthroscopy. Physical examination on 11/14/2013 revealed the injured worker in constant and intermittent pain. The pain was reported to radiate to the left lower extremity. The pain was rated a 7/10. The least amount of pain was a 4/10. Examination of the cervical spine revealed mild tenderness to palpation. Cervical spine testing showed slightly decreased range of motion in flexion, extension, lateral flexion, and rotation. Spurling maneuver was negative. Examination of the lumbar spine revealed tenderness to palpation across the lower back. Lumbar spine testing revealed decreased range of motion in flexion, extension, lateral flexion, and rotation. There was no significant weakness with the upper or lower extremities. Reflex testing was asymmetrical. Sensory was intact. Straight leg raising test in the sitting position was to 90 degrees with pain on the left, no pain on the right. Medications were Vicodin 5/500 mg and Voltaren 75 mg. Treatment plan was for a lumbar epidural steroid injection at the L4-5 level. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

MEDIAL BRANCH BLOCK L4-5: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Medial Branch Block

Decision rationale: The decision for MEDIAL BRANCH BLOCK L4-5 is not medically necessary. The ACOEM Guidelines indicate that a facet neurotomy (rhizotomy) should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As ACOEM does not address specific criteria for medial branch diagnostic blocks, secondary guidelines were sought. The Official Disability Guidelines indicate the criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain, which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings (although pain may radiate below the knee), and a normal straight leg raise exam. There should be documentation of failure of conservative treatment, 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 should be injected in 1 session. Additionally, 1 set of diagnostic medial branch blocks is required with a response of 70%, and it is limited to no more than 2 levels bilaterally. The 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 (a procedure that is still considered under study). The injured worker had an epidural steroid injection on 06/10/2013, and then had a followup appointment on 06/18/2013 with reports of increased pain in the low back and left lower extremity that was persistent. She reported 0 changes to her condition since her last evaluation. Her pain was reported a 5/10 on the VAS scale. The injured worker had a positive straight leg test on physical examination dated 11/14/2013. The injured worker's examination revealed tenderness to palpation across the lower back. The medical guidelines state that there should be facet joint pain, which includes tenderness to palpation at the paravertebral area, a normal sensory examination, and absence of radicular findings. Also, there should be a normal straight leg raise exam. The injured worker had findings of radicular symptoms. Therefore, this request is not medically necessary.

MEDIAL BRANCH BLOCK L5-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Medial Branch Block

Decision rationale: The decision for MEDIAL BRANCH BLOCK L5-S1 is not medically necessary. The ACOEM Guidelines indicate that a facet neurotomy (rhizotomy) should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As ACOEM does not address specific criteria for medial branch diagnostic blocks, secondary guidelines were sought. The Official Disability Guidelines indicate the criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain, which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings (although pain may radiate below the knee), and a normal straight leg raise exam. There should be documentation of failure of conservative treatment, 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 should be injected in 1 session. Additionally, 1 set of diagnostic medial branch blocks is required with a response of 70%, and it is limited to no more than 2 levels bilaterally. The 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 (a procedure that is still considered under study). The injured worker had an epidural steroid injection on 06/10/2013, and then had a followup appointment on 06/18/2013 with reports of increased pain in the low back and left lower extremity that was persistent. She reported 0 changes to her condition since her last evaluation. Her pain was reported a 5/10 on the VAS scale. The injured worker had a positive straight leg test on physical examination dated 11/14/2013. The injured worker's examination revealed tenderness to palpation across the lower back. The medical guidelines state that there should be facet joint pain, which includes tenderness to palpation at the paravertebral area, a normal sensory examination, and absence of radicular findings. Also, there should be a normal straight leg raise exam. The injured worker had findings of radicular symptoms. Therefore, this request is not medically necessary.