

Case Number:	CM13-0050130		
Date Assigned:	04/14/2014	Date of Injury:	11/18/2008
Decision Date:	05/23/2014	UR Denial Date:	10/11/2013
Priority:	Standard	Application Received:	11/11/2013

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 Occupational Medicine 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 patient is an employee of [REDACTED] and has submitted a claim for mechanical low back pain; failed back syndrome - lumbar; lumbar degenerative disk disease; left lower extremity radiculopathy; and probably lumbar facet joint arthropathy associated with an industrial injury date of 11/18/2008. Treatment to date has included microdiscectomy at L3-L4 and repair of a sciatic disk in 2002, laminectomy and fusion at L4-L5 and S1 in 2008, L3-L4 fusion in 2011, physical therapy x 16-20 visits, lumbar epidural steroid injection on unspecified date, spinal cord stimulator, TLSO brace, and medications including Dilaudid, Percocet, Lyrica, and Exalgo. Utilization review from 10/11/2013 denied the request for bilateral L4, L5, S1 medial branch nerve block because patient had a previous fusion from L3-S1 as well as left lower extremity radiculopathy which would be a contraindication for doing facet blocks. Medical records from 2013 to 2014 were reviewed showing that patient has been complaining of constant low back pain with occasional lower extremity pain radiating down the ankle and feet. The leg pain primarily occurred while sitting or lying on his side. He required assistance with most aspects of personal care. He was unable to push, pull, knee, bend, squat, climb stairs, sit, stand or walk beyond 30 minutes. Physical examination showed tenderness with stiffness at lumbar paraspinous muscles. Range of motion of lumbar spine showed limitation towards all planes with increased pain during extension. Motor strength was 5/5 at all extremities. Deep tendon reflexes were equal and symmetric. Gait was mildly antalgic. Patient was able to stand on toes and walk on heels bilaterally. MRI of the lumbar spine, dated 05/31/2013, documented postsurgical changes from bilateral laminectomy, with fusion and instrumentation from L3-L4 through L5-S1. No significant stenosis was noted at any of the postrsurgical levels. A recent appearing 50% compression at L1 was noted with retropulsion and 20% anterior superior compression without retropulsion at L2. Moderate resulting canal and lateral recess stenosis was

demonstrated lateralizing to the left at T12-L1. There was associated crowding at the conus but no obvious frank compression or evidence for myelomalacia or edema. Mild spondylosis and small chronic appearing disk protrusions were noted without significant stenosis at L2-L3. Repeat MRI of the lumbar spine, dated 07/17/2013, revealed previous L1 compression fracture with slight retropulsion and kyphosis which is definitely touching the distal end of the conus. There were no signal changes in the conus. There was evidence of previous fusion with pedicle screws from L3 to S1 and this appeared to be all posterolateral and no interbodies present. The patient had some mild degenerative changes above the fusion but minimal. There was no evidence of canal stenosis at the level of the fusion done. There was evidence of previous laminectomy noted. CT scan of the lumbar spine, dated 09/20/2013, revealed postsurgical changes showing interpedicular screws in L3, L4, L5 and S1 vertebrae. There were laminectomies of L3, L4, and L5 vertebrae and associated disk space losses. There appeared a spacer in L4-L5 interspace. There was burst / wedge compression fracture of L1 vertebra, showing approximately 70% loss of body height. There was retropulsion of the superior posterior endplates, and this caused moderate-to-severe spinal canal stenosis. Associated comminuted fracture of the right lamina involved the right L1-L2 articular facet. Compression fracture of the L2 vertebra showed approximately 20% loss of body height. Associated disk bulge of L2-L3 caused mild to moderate spinal canal stenosis. No other fractures were seen. Paravertebral soft tissues were normal.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L4, L5, S1 medial branch nerve block: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

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 Chapter, Medial Branch Block.

Decision rationale: CA MTUS does not specifically address medial branch blocks. ODG states that medial branch blocks are not recommended except as a diagnostic tool for patients with non-radicular low back pain limited to no more than two levels bilaterally. 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 patient had a history of laminectomy and fusion at L4-L5 and S1 in 2008, and L3-L4 fusion in 2011. Furthermore, the patient also has a history of radicular pain based from the subjective findings. A rationale for the procedure written on 09/09/2013 stated that the plan is bilateral L3-L4 medial branch nerve block due to the presence of facet joint hypertrophy on those levels in recent MRI. However, the present request specified a different level. For the above reasons, the guideline criteria have not been met. Therefore, the request for bilateral L4, L5, S1 medial branch nerve block is not medically necessary and appropriate.