

Case Number:	CM13-0055732		
Date Assigned:	12/30/2013	Date of Injury:	03/06/2009
Decision Date:	03/27/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	11/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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 physician 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 a 54 year old female who reported an injury on 03/06/2009. The mechanism of injury was noted to be the patient was helping a client get out of the bathtub when the client lost his balance and fell on the patient. The patient struck her back on the edge of the cabinet behind her and tried to break her fall and hit her left small finger, and eventually the patient was noted to fall to the floor with the client, weighing approximately 310 pounds, on top of her. A physical examination dated 09/09/2013, revealed the patient had decreased range of motion of the lumbar spine with tenderness over the distal one third. The patient had tenderness over the facets at the L4-5 and L5-S1 level. The patient had positive facet loading on the left. The patient was unable to perform a straight leg raise on the left side because of a CVA (cerebrovascular accident), and the patient was 70 degrees on the right. The diagnoses were noted to include lumbosacral spine disease at L4-5 and L5-S1 with anterolisthesis of L4 over L5, lumbar facet arthropathy, lumbar radiculopathy, and cervical sprain/strain with facet arthropathy, more on the left. The treatment and recommendations were noted to be physiotherapy deferred to the primary treating physician, a facet block at L4-5 and L5-S1 on the left medial branches, and continuation of medications Norco, gabapentin, and Flexeril.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient second lumbosacral facet block at the left L4-L5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation, 2013 web-based edition. California MTUS Guidelines, web-based edition: <http://www.dir.ca.gov/t8/ch4>

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 Chapter, Medial Branch Block.

Decision rationale: ACOEM Guidelines indicate that facet joint injections are not recommended for the treatment of low back disorders. However, 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. The ACOEM guidelines do not address the criteria for Medial Branch Blocks. As such, there is the application of the Official Disability Guidelines, which indicate that facet joint medial branch blocks as therapeutic injections are not recommended except as a diagnostic tool as minimal evidence for treatment exists. The Official Disability Guidelines recommend that for the use of diagnostic blocks, the patient have facet-mediated pain which includes tenderness to palpation in the paravertebral area over the facet region, a normal sensory examination, absence of radicular findings and a normal straight leg raise exam. Additionally, one set of diagnostic medial branch blocks is required with a response of 70%, and it is limited to no more than 2 levels bilaterally and they 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"). The clinical documentation submitted for review indicated the patient had tenderness to palpation in the paravertebral area over the facet region. However, there was a lack of documentation indicating the patient had a positive sensory examination and absence of radicular findings. The patient was noted to be unable to perform a normal straight leg raise examination on the left due to a cerebrovascular accident. There was a lack of documentation of a prior injection and the patient's objective response. It was indicated this was a second injection. However, repeat injections are not recommended. Given the above and the lack of clarification indicating whether this was a first injection or second injection, there was a lack of documentation of a normal sensory examination and an absence of radicular findings to support the necessity. Given the above, the request for an outpatient second lumbosacral facet block at the left L4-5 and L5-S1 is not medically necessary.