

<b>Case Number:</b>	CM13-0055736		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	02/12/2013
<b>Decision Date:</b>	03/21/2014	<b>UR Denial Date:</b>	11/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 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 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 56-year-old male who was involved in a motor vehicle accident on 02/12/2013, with multiple injuries to the shoulders, arms, neck, low back, and left knee. Prior treatment was conservative and included physical therapy, chiropractic sessions, lumbar epidural steroid injection (ESI), home exercise program, modified duties, rest, and medication. A report dated 06/28/2013 for an MRI of the lumbar spine without gadolinium revealed there were five (5) lumbar-type, non-rib bearing vertebral bodies. Alignment was normal throughout, with mild straightening of the normal lumbar lordosis. The vertebral bodies showed no evidence of fractures. The marrow signal was normal, with no focal masses. Posterior elements were normally aligned throughout, with no evidence of pars defects or prior surgery. There was mild disc desiccation throughout, multilevel mild bulging without herniation of the nucleus pulposus, and no evidence of discitis osteomyelitis. There was no significant spinal canal stenosis due to acquired factors. The Conus was terminated at T12-L1. The visualized lower cord signal was normal. There were no epidural fluid collections. T12-L1 had normal disk and facet joints. L1-L2 had normal disk and facet joints. L2-L3 showed minimal bilateral foraminal disc protrusions with mild facet arthropathy. There was no evidence of significant spinal canal or neural foraminal stenosis. L3-L4 had mild disc desiccation and very mild broad based disc bulge with mild facet arthropathy. There was no significant spinal canal narrowing. There were bilateral mild foraminal disc protrusions, which caused mild neural foraminal narrowing bilaterally. L4-L5 revealed minimal bilateral foraminal protrusions with no significant spinal canal or neural foraminal stenosis. There was minimal narrowing of the left lateral recess, with abutment of the traversing left L5 nerve root, axial image number eleven (11). There was moderate bilateral facet arthropathy. L5-S1 showed desiccated disc, with mild broad-based disc bulge and no evidence of spinal canal stenosis or S1 nerve root abutment. There was moderate bilateral foraminal disc

protrusions, causing moderate neural foraminal narrowing bilaterally without compression of the exiting nerve roots. There was mild facet arthropathy. An operative report, dated 08/23/2013 was for an epidural steroid to L5-S1. The patient's physical examination on 10/23/2013 showed limited range of motion in the low back in all directions to about 65% of normal limits. The patient had more pain with extension and oblique rotation on the left side. The patient had difficulty walking on heels and toes, but was able to do it. There was normal range of motion in the hips, knees and ankles. Manual muscle testing revealed the muscle strength to be 5/5 throughout the bilateral lower extremities. A sensory examination was unremarkable. Deep tendon reflexes were 2+ at the knees and 1+ at the ankles. Straight leg raising was negative. The patient had tight hamstrings, more on the right side. There was no tenderness to palpation on the right greater trochanter and mild tenderness over the left greater trochanter. Diagnoses showed a degenerative lumbar disc, lumbar disc disease, lumbar facet joint disease, and left knee injury. The request is for one (1) trial of L4-5, L5-S1 medial branch blocks for the L4, L5 and S1 medial branches.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**One (1) trial of L4-5, L5-S1 medial branch blocks for the L4, L5 and S1 medial branches:**  
Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Lumbar & Thoracic (Acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chapter - Lumbar & Thoracic (Acute and Chronic), Facet joint diagnostic blocks (injections)

**Decision rationale:** The patient has tried and failed conservative care, including physical therapy, chiropractic sessions, lumbar epidural steroid injection (ESI), home exercise program, modified duties, rest, and medication. There is MRI evidence of facet arthropathy at L4-L5 and L5-S1. He continues to have non-radicular pain and objectively, he was noted to have limitation in lumbar MOR, but normal straight leg raises (SLR), motor strength 5/5 in the lower extremities, sensation intact in the lower extremities, and deep tendon reflexes (DTRs) symmetrical in the lower extremities. As per the Official Disability Guidelines, he has met the criteria for one (1) trial of L4-5, L5-S1 medial branch blocks for the L4, L5 and S1 medial branches and hence the request is certified.