MAXIMUS Federal Services

Case Number:	CM13-0057617		
Date Assigned:	12/30/2013	Date of Injury:	09/07/1993
Decision Date:	04/01/2014	UR Denial Date:	11/11/2013
Priority:	Standard	Application Received:	11/25/2013

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 67-year-old male who reported injury on 09/07/1993. The mechanism of injury was noted to be an explosion. The patient was noted to have 2 ACDFs, one in 2011 and one in 2012. The patient was noted to have left lower leg pain following a tib/fib and heel fracture in 2011 which required a fusion with plates and screws. The patient was treated with physical therapy many years ago and did not have a home exercise program. It was indicated the patient had never had injection therapy for his neck. The patient had an MRI on 08/02/2013 which was reported to indicate the patient had impression on the thecal sac from L4-5 and bilateral stenosis with left L4 impingement, L5-S1 HNP which impressed the thecal sac with foraminal stenosis. Physical examination revealed the patient had tenderness to palpation at L4-5 and L5-S1 bilaterally. The patient had a positive quadrant test bilaterally. The patient had a negative straight leg raise. The patient had decreased sensation in the right upper extremity at C7-8. The patient's reflexes were 1+ bilaterally. The patient diagnoses were noted to include pain in joint, ankle and foot and lower leg, lumbago, brachial neuritis or radiculitis nos, pain in the thoracic spine, cervicalgia, postlaminectomy syndrome in the cervical region, and lumbago. The treatment plan was noted to include a bilateral L4-5 and L5-S1 facet injection under fluoroscopic guidance and a urine drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

bilateral facet injections under fluoroscopic guidance L4-5 and 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 Chapter, Medial Branch Block Section

Decision rationale: The California 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. ACOEM guidelines do not address the criteria for Medial Branch Blocks. As such, there is the application of the Official Disability Guidelines (ODG), which indicates 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. The clinical documentation submitted for review indicated the patient had tenderness to palpation in the paravertebral area over L4-5 and L5-S1 bilaterally. The patient had a normal straight leg raise examination. There was a lack of documentation indicating the patient had a normal sensory examination as there was no documentation of dermatomal or myotomal findings. There was not documentation that the patient had the absence of radicular findings. Given the above and the lack of documentation, the request for bilateral facet injection under fluoroscopic guidance L4-5 and L5-S1 is not medically necessary.

UDT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Section Page(s): 78.

Decision rationale: The California MTUS indicates that the use of urine drug screening is for patients with documented issues of abuse, addiction, or poor pain control. The clinical documentation submitted for review failed to provide documentation the patient had issues of abuse, addiction or poor pain control to support a urine drug screen. Given the above, the request for urine drug screen is not medically necessary.