

Case Number:	CM13-0066244		
Date Assigned:	01/08/2014	Date of Injury:	11/26/2012
Decision Date:	10/24/2014	UR Denial Date:	11/05/2013
Priority:	Standard	Application Received:	12/16/2013

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 and is licensed to practice in Maryland. 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 employee was a 39 year old male status post industrial injury on 11/26/12. The mechanism of injury was back pain after reaching from his driver's seat to pick up a water bottle. MRI of lumbar spine that was done on 12/20/12 showed anterolisthesis of L5 with respect to L4 of approximately 6 mm. L4-L5 annular tear noted with left paracentral protrusion measuring 6mm in AP diameter which may contact ventral aspect of left L5 nerve root and results in proximal left NFS. Mild bilateral facet degenerative changes noted at L4-5. At L5-S1 level, anterolisthesis of L5 with respect to L4 noted and disc bulge to left with small annular tear. Mild bilateral facet degenerative changes and mild bilateral caudal NFS noted. His prior treatment included Physical therapy, Chiropractic therapy and left L3, L4 and L5 lumbar medial branch blocks that was done in 09/05/13. His medications included Ultracet, Nabumetone and Escitalopram. The progress note from 10/28/13 was reviewed. He reported 50-60% increase in his lumbar axial pain. He was awaiting consultation with spine surgeon. He was taking Ultracet, 4 tablets a day for pain control. Examination was significant for tenderness over the lower lumbar facet joints, left L4-5 facet and paraspinal muscles. Straight leg raising test was negative and strength was normal in bilateral lower extremities. Deep tendon reflexes were symmetrical and sensory exam was normal. Assessment included lumbosacral pain, lumbar axial pain due to facet arthropathy and L4-5 and L5-S1 annular tears with possible left L5 nerve root impingement and bilateral L5 pars defect with L4 on L5 anterolisthesis. Plan of care included continuing Ultracet, Nabumetone and authorization for left L4-5 and L5-S1 lumbar facet MBBB as patient's lumbar axial pain has increased with positive left facet maneuver noted. It was also noted that he was status post left L4-5 and L5-S1 lumbar facet steroid injections with >50% improvement in lumbar axial pain. He was continuing to be prescribed Ultracets 2 tabs every 6 hours and Nabumetone BID before and after the medial branch blocks.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT L4-5 AND L5-S1 FACET MEDIAL BRANCH BLOCK (MBB) TO LUMBAR SPINE: Upheld

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

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 complaints, facet joint medial branch block

Decision rationale: The employee was a 39 year old male status post industrial injury to lower back. His prior treatment included Physical therapy, Chiropractic therapy and medial branch blocks at left L3, L4 and L5. MRI of lumbar spine that was done on 12/20/12 showed anterolisthesis of L5 with respect to L4 of approximately 6 mm. L4-L5 annular tear noted with left paracentral protrusion measuring 6mm in AP diameter which may contact ventral aspect of left L5 nerve root and results in proximal left NFS. Mild bilateral facet degenerative changes noted at L4-5. At L5-S1 level, anterolisthesis of L5 with respect to L4 noted and disc bulge to left with small annular tear. Mild bilateral facet degenerative changes and mild bilateral caudal NFS noted. A request was sent for left L4-5 and L5-S1 lumbar facet MBBB. According to Official disability guidelines, 50% or more reduction of pain relief is required for repeat procedure and for an intervention to be considered successful functional improvements must be documented. After the medial branch blocks, pain was reportedly 50-60% better without decrease in use of Ultracet and without documentation of functional improvement of pain. Based on the medical records reviewed, guideline criteria for a repeat procedure have not been met. The request for repeat medial branch block is not medically necessary or appropriate.