

Case Number:	CM14-0105869		
Date Assigned:	07/30/2014	Date of Injury:	12/15/2012
Decision Date:	10/08/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/09/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain 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 injured worker is a 32-year-old male who reported an injury on 12/15/2012 due to lifting heavy boxes and felt a snap to his back. The injured worker complained of lower back pain. The injured worker had diagnoses of chronic pain syndrome, degenerative disc disease at the lumbar spine, radicular symptoms of the lower extremities, and lumbar spondylosis. The past treatments included physical therapy, medication, cortisone injections, electromyogram, and nerve conduction study. The past surgical procedure included a laminectomy. The MRI of the lumbar spine dated 04/28/2014 revealed a superimposed broad based central disc extrusion bulge at the L4-5 and a bulge with superimposed right paracentral lateral recessed disc extrusions at the L5-S1 and status post a laminectomy on the L5-S1 to the right. The electromyography and nerve conduction study revealed bilateral lower extremities consistent with S1 radiculopathy. The physical examination dated 05/07/2014 of the lumbar spine revealed a well healed midline surgical scar approximately 5 cm clean, dry, and intact. Slight scoliotic curvature at the thoracolumbar junction. Lordotic curvature appeared intact. Range of motion was full to all planes with the exception of the lateral side bending with right at the axle as well as radicular pain symptoms. Flexion limited by pain, however, flexion was approximately 35 degrees and extension revealed radicular pain to the right lower extremity. Motor was 5/5 bilaterally. Sensation grossly intact. Deep tendon reflexes 2+/4. Positive right leg raise of the lower extremity. Positive facet loading bilaterally. The medications included Celebrex and Lyrica with a reported pain of 8/10 to 9/10 using the VAS. The Request for Authorization dated 05/27/2014 was submitted with the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L3-S1 facet medial branch injection under fluoroscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The California ACOEM Guidelines indicate that a facet neurotomy should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As ACOEM does not address medial branch diagnostic blocks, secondary guidelines were sought. Official Disability Guidelines indicate the criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings although pain may radiate below the knee, and a normal straight leg raise exam. There should be documentation of failure of conservative treatment including home exercise, physical therapy, and NSAIDS prior to the procedure for at least 4 to 6 weeks and no more than 2 facet joint levels should be injected in 1 session. Additionally, 1 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 1 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 notes indicated that the injured worker is positive for radicular pain. The clinical notes did not indicate that conservative therapy had failed. As such, the request for Bilateral L3-S1 facet medial branch injection under fluoroscopy is not medically necessary.