

Case Number:	CM14-0165162		
Date Assigned:	10/10/2014	Date of Injury:	09/02/2011
Decision Date:	11/26/2014	UR Denial Date:	10/06/2014
Priority:	Standard	Application Received:	10/07/2014

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 Orthopedic surgery 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:

This is a 58 year-old male with a 9/2/11 date of injury. Mechanism of injury was working freight and lifting heavy merchandise. The patient was most recently seen on 5/22/14 with complaints of lumbar spine pain rated at 2-3/10 at rest, increasing to 3-4/10 with activities of daily livings. Exam findings revealed lumbar tenderness in the midline L4-5-S1. Range of motion was recorded as 30-degrees flexion, and 10-degrees of extension with pain. Neurological exam showed a depressed left ankle reflex, and weakness of the left EHL. There was mention of an MRI in a supplemental report dated 5/27/14 (actual MRI report not included). It stated that the MRI documented lateral disc protrusion, L5-S1, multi-level disc disease, and L5-S1 foraminal stenosis. This Report also documents an ESI at the L2-3 level, which, according to the patient, helped his leg pain but not his back pain. A subsequent ESI at the L4-5 level performed on 7/23/12 is recorded in the UR report of 10/16/14. This report also notes that facet injections were performed in 2012 (L2-3), and again (L4-5 and L5-S1) on 8/28/14. No documentation is provided after this date, so the patient's response to the facet injections is unknown. The patient's diagnoses included HNP, L4-5; and Degenerative disc disease. Significant diagnostic Tests include MRI of the lumbar spine. Treatment to date includes medications, lumbar spine epidural steroid injection, and facet joint injections. An adverse determination was received on 10/6/14 due to inadequate documentation regarding the effect of a recent lumbar facet injection at these two levels. Official Disability Guidelines (ODG) recommended this procedure only with a prior diagnosis of facet joint pain using a medial branch block.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurectomy L4-5 & LS-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter

Decision rationale: CA MTUS states that facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. In addition, Official Disability Guidelines (ODG) criteria for RFA include at least one set of diagnostic medial branch blocks with a response of 70%, no more than two joint levels will be performed at one time, and evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. This patient has been under treatment for a lower back injury that occurred 3 years ago. On his most recent exam, he complained of moderate non-radicular back pain which worsened with physical activity. Physical exam revealed restricted range of lumbar flexion, as well as limited extension with pain. Neurological exam showed a depressed left ankle reflex, and weakness of the left EHL. There was mention of an MRI, which documented multi-level disc disease and foraminal stenosis. There was no mention of facet degeneration or hypertrophy. The patient has also had an ESI at the L4-5 level, which was appropriate to the neurological findings on physical exam. The current request is for neurectomy at L4-5 and L5-S1. Both CA MTUS and ODG guidelines stipulate that neurotomy/neurectomy are indicated only after at least one set of diagnostic medial branch blocks, with a significant, measurable improvement. This patient does have clinical signs of facet joint disease, and did undergo facet injections at the L4-5 and L5-S1 levels on 8/28/14. However, no documentation was provided as to the patient's clinical response to the diagnostic blocks. Therefore, the request for neurectomy L4-5 & L5-S1 is not medically necessary.