

Case Number:	CM14-0169834		
Date Assigned:	10/17/2014	Date of Injury:	10/29/2011
Decision Date:	11/24/2014	UR Denial Date:	09/19/2014
Priority:	Standard	Application Received:	10/13/2014

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 Arizona. 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 55-year old male sustained a work-related injury on 10/29/2014. Detail of mechanism and mechanism involved was not available. His job description was also not documented except that he was employed by work an entertainment company. I did not receive any documentation of initial treatment or proof of completing a conservative regime. He had L5-S1 procedure in 1987 and anterior/posterior L5-S1 interbody fusion in April 2013. On 7/1/2014 he had constant complaints of low back pain radiating to lateral aspect of thighs and radiating left lower extremity pain. Although there is some confusion in the documentation regarding the proposed site of MBB being left, right or bilateral, I assume the left side will be first followed by the right side if successful. Pain rated as 5/10 to 9/10 and he reported 40-60 % pain relief due to pain-medication. Stated on 5/28/2014 continued low back pain [5-7/10 and continued radicular pain]. Had a MRI of lumbar spine [8/7/2012] taken shortly after DOI and 2 done more recently with/without contrast [5/30/2014 and 6/24/2014]. The pathology taken from MRI's was basically left L4-5 facet arthropathy and slight abutting of the L5 nerve root left sided facet arthrosis with bony impingement of the left L5 nerve root. Stated on 9/2/2014 that he had both arthritic and radicular pain and felt his symptoms were due to degeneration of lumbar or L/S intervertebral disc [722.52], thoracic or L/S neuritis or radiculitis [724.4] or post laminectomy syndrome [722.83]. Suggested medial branch block [MBB] procedure and patient requested surgical evaluation. On 7/8/2014 he reported that radiating pain has become tolerable and recent onset of depression. On 7/8/2014 the physical examination revealed motor examination was normal, sensation testing was decreased both thighs, deep tendon reflexes [DTR] showed patella reflex right+ and left trace and straight leg raise [SLR] was found to be negative. Radiologist at time of MRI on 6/24/2014 noted prior disc replacement and no reference to this procedure in documents. Physical examination [PR-2 on 7/1/2014] revealed normal gait, neurologic

examination lower extremities [LE's], normal bulk & tone lower extremities, ROM diminished and painful, sensation diminished bilaterally over lateral aspects of thighs, DTR diminished R lower extremity and SLR negative bilateral [also reported SLR seated positive one time.] Treatment rendered since day of injury include, L5-S1 discectomy and repair of meningocele in 1987 and left shoulder surgery was done in 2007. Medications are Percocet, Senna, Motrin, MS Contin, Nortriptyline Hydrochloride, Lyrica, Gralise, Effexor, Kohana and Soma. Diagnostic studies consisted of MRI lumbar spine on 6/24/2014 and LBP with radiculopathy. Prior disc replacement & decompression/fusion L5-S1, focal arthropathy T11-12, no disc bulge or protrusion, L4-5: Left facet arthropathy may slightly about the descending left L5 nerve root. MRI lumbar spine with contrast on 5/30/2014 with no major changes except interval L5-S1 anterior & posterior fusion and an MRI lumbar spine with contrast on 8/7/2012. Bilateral laminectomy & spinectomy with pedicle screw fusion at L5-S1 and since last study had anterior L5-S1 fusion with hardware.L1-4 negative, L4-5 showed only mild bilateral facet arthrosis, L5-S1: At this level artifact obscure left-sided detail. There is no central spinal canal stenosis, right lateral recess stenosis.Diagnosis was documented as degeneration of lumbar or lumbo-sacral intervertebral disc, thoracic or L/S neuritis or radiculitis, post laminectomy syndrome. Recommendations: - Bilateral L3 Medial Branch Blocks and if effective proceed with Medial Branch neurotomy. Should note that L4-5 facet joint is innervated by L3 medial branch superiorly AND the L4 medial branch inferiorly. Patient asked to be referred to a surgeon. UR denial date was 9/19/2014. Work status: Temporarily disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial Branch Block, Left L3 x 1, as an outpatient: 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): 653, 660 Table 1,Chronic Pain Treatment Guidelines Physical methods Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar spine, Diagnostic medial branch block[MBB]

Decision rationale: My decision is based on review of the medical records, MTUS, ACOEM Practice Guidelines Plus and Title 8 Section 9792.6(a) of the California Code of Regulations. ACOEM notes in regards to diagnostic facet injections that they are not recommended for acute or sub-acute low back pain or radicular pain syndromes. The Official Disability Guide expands on this and states that facet injections are "limited to patients with low-back pain that is non-radicular." This patient continues with ongoing complaints of low back pain radiating into both buttocks with numbness and tingling. Examination findings have consistently documented decreased sensation of the lateral leg correlating with an L5 nerve root and L4-5 disc. As such, the radiculopathy precludes medial branch blocks, per evidence-based guidelines. As aforementioned by referring physician his treatment recommendation is to follow the appealed medial branch blocks, if successful, with radiofrequency neurotomy. As such, I refer to the ACOEM evidence based guideline for radiofrequency neurotomy, as cited below, which states

that radiofrequency neurotomy, facet neurotomy, radiofrequency lesioning, radiofrequency thermo coagulation or radiofrequency ablation are not recommended for all chronic lumbar spine disorders. The ODG further notes that "Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated." On review of the medical records, patient asked for referral to a surgeon. No documentation of surgeon's recommendation[s] in my documentation. My recommendation would be to obtain and review carefully a surgical consultation prior to continuing on the MBB-path. The L4-5 findings correlate well with stabilization of a functional unit [in this case L5-S1] resulting in more stress on the adjoining level [in this case L4-5]. This patient is doing fairly well following his L5-S1 multiple surgeries and may be a candidate for stabilization at the so-called adjoining level. If after surgical consultation the surgeon and the patient decline a surgical option, MBB could then be a feasible option. No documentation of conventional conservative care was found and therefore functional improvement cannot be judged. Facet joints are known to a source of pain in some individuals. However, diagnostic blocks are rarely necessary since most patients respond to initial conservative therapy.