

Case Number:	CM14-0022132		
Date Assigned:	05/09/2014	Date of Injury:	12/22/2009
Decision Date:	07/10/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	02/21/2014

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 Internal 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 58-year-old male. On December 22, 2009, he felt a pop in his back when he lifted a manway off a gas tank, but this time the pain did not subside. In January 2010, he received medication for pain, and physical therapy. He has had three (3) epidural spinal injections. He chronically uses opioid pain medicines and ibuprofen three (3) times a day. On July 13, 2011, a treating physician described 5-9/10 low back pain, aggravated by prolonged driving and sitting, pain in the posterolateral aspect of both lower limbs with burning and paresthesias in both legs. On examination, deep tendon reflexes were 2+ and equal at the knee, absent in the right ankle, with diffusely diminished sensation in the right lower extremity. No other neurological deficits were noted. A low back x-ray on July 13, 2011, revealed signs of a prior L5 laminotomy, with moderate loss of disk space at L4-5 with 1-2 mm retro-listhesis of L5-S1 as well as degenerative changes in the facets at L5-S1 bilaterally. An MRI of the lumbar spine report dated January 25, 2010 did not show compromise of nerve roots. A more recent MRI of the lumbar spine study on January 13, 2014, revealed mild bilateral L5-S1 and L4-5 foraminal narrowing, as well as mild disk/end plate degeneration with trace retrolisthesis at L3-4 and L4-5. There was no evidence of nerve roots compression. On January 16, 2014, another treating physician saw the injured worker in his office and noted facet arthropathy at L4-5, presumably on the basis of imaging findings, as there were no specific physical findings described to support this diagnosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL FACET INJECTION RADIOFREQUENCY LESION TO THE MEDIAL FACET AT L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301, 304.

Decision rationale: The treating physician appears to have concluded that the injured worker's low back and right radicular pain might be due to L4-5 facet arthropathy on the basis of x-ray findings of arthropathy at that level. There were no physical findings noted to support such a diagnosis. Facet arthropathy does not cause radiculopathy. The MTUS/ACOEM Guidelines state that depending solely on imaging studies only is insufficient and can cause diagnostic confusion. Also, one (1) diagnostic facet joint injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments, such as non-steroidal anti-inflammatory drugs (NSAIDs), aerobic exercise, other exercise, and manipulation in order to determine whether specific interventions targeting the facet joint are recommended. Repeated diagnostic injections in the same location(s) are not recommended. There is no recommendation in the guidelines for or against the use of radiofrequency neurotomy, neurotomy, or facet rhizotomy for treatment of patients with chronic low back confirmed with diagnostic blocks, but who do not have radiculopathy and who have failed conservative treatment. The injured worker has chronic low back pain with bilateral lower extremity radiculopathy, so radiofrequency lesion/neurotomy is not indicated according to the guidelines. In any event, this procedure is not supported by quality evidence, so the requested procedure is not medically indicated.