

Case Number:	CM14-0022965		
Date Assigned:	05/14/2014	Date of Injury:	06/21/2012
Decision Date:	07/10/2014	UR Denial Date:	02/07/2014
Priority:	Standard	Application Received:	02/24/2014

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 Anesthesiologist, Pain Medicine and is licensed to practice in Florida. 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 45 year old male who reported an injury on 06/21/2012. The mechanism of injury was not provided. The diagnoses included low back pain and lumbar radiculopathy. An MRI of the lumbar spine performed 01/09/2014 was noted to show postsurgical changes consistent with left L5-S1 laminectomy, and a left posterior disc bulge with annular tearing at L4-5 without significant neural foraminal stenosis. Per the 01/21/2014 clinical note, the injured worker reported low back pain rated 7/10 and left leg pain rated 2/10. Objective findings included 4+/5 strength in the left lower extremity, absent pinprick sensation in the left L2-S1 distributions, 1-2+ reflexes bilaterally, and a positive straight leg raise on the left. The provider recommended a left diagnostic block at L4-5 and L5-S1, as the injured worker had no evidence of ongoing or new radiculopathy. The provider noted his previous radiculopathy had been treated. Per the 03/04/2014 clinical note, the injured worker reported low back pain rated 8/10 and left leg pain rated 7-8/10 with associated numbness and tingling. Objective findings included 4 to 4+/5 strength throughout the left lower extremity, left paraspinal muscle spasm, absent pinprick sensation in the left L2-S1 distributions, absent left gastrocnemius reflex, and a positive straight leg raise on the left. The provider recommended the injured worker's care be transferred to a pain management specialist since there was no indication for further invasive treatment modalities.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT MEDIAL BRANCH BLOCK L3-4, L4-5, BILATERAL RAMUS, WITH FLUOROSCOPY: Upheld

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

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

Decision rationale: CA MTUS/ACOEM states invasive techniques (e.g., local injections and facet joint injections of cortisone and lidocaine) are of questionable merit. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The Official Disability Guidelines further state, diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. The use of diagnostic blocks for facet pain should be limited to patients with low-back pain that is non-radicular. There should also be documentation of failure of conservative treatment for at least 4-6 weeks. The medical records provided indicate the injured worker did have radicular symptoms. He demonstrated decreased strength, reflexes, and sensation, as well as a positive straight leg rise on the left. Therefore, the use of a medial branch block is not supported by guidelines. In addition, there is a lack of documentation regarding failure of conservative care. Therefore, the request for left medial branch block L3-4, L4-5, bilateral ramus, with fluoroscopy is not medically necessary.