

Case Number:	CM14-0032298		
Date Assigned:	06/20/2014	Date of Injury:	05/28/2013
Decision Date:	07/18/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/13/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 49-year-old female who reported an injury on 05/28/2013. The mechanism of injury was noted to be a fall. The injured worker's prior treatments were noted to be chiropractic care and acupuncture. Her diagnosis was noted to be cervical radiculopathy. The injured worker had a clinical evaluation on 01/31/2014. She complained of neck, mid back and low back pain. She rated her pain a 6/10 and denied any radiation into her lower extremities. The injured worker used ketoprofen, Flexeril and Terocin patches for pain control. The objective findings included tenderness to palpation of the lumbar spine. She had diminished sensation of the right L3, L4, L5 and S1 dermatomes. The progress report included information regarding an MRI dated 11/01/2013. The impression showed degenerative disc disease and facet arthropathy at L5-S1 without evidence of canal stenosis or neural foraminal narrowing at any level. There was a discussion about treatment options. The patient decided to try a medial branch block at L4-5. Future considerations included a rhizotomy. The request for authorization for medical treatment was dated 01/31/2014. The provider's rationale for the requested medial branch block bilaterally was noted to be due to the diagnostic properties attributed to the procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial Branch Block Bilaterally at L4-L5 (2): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back.

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 medial branch blocks.

Decision rationale: The request for a medial branch block bilaterally at L4-L5 (2) is not medically necessary. The California MTUS/American College of Occupational and Environmental Medicine indicate facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The Official Disability Guidelines indicate diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to a facet neurotomy at the diagnosed levels. The Official Disability Guidelines also indicate criteria for use of diagnostic blocks. The clinical evaluation should include facet joint pain signs and symptoms over the joint levels requested. Diagnostic blocks are limited to patients with low back pain that is nonradicular and at no more than 2 joint levels bilaterally. There must 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. There can be no more than 2 facet joint levels injected in 1 session. Diagnostic facet blocks should only be performed in patients in whom a surgical procedure is anticipated. Diagnostic facet blocks should not be performed on patients who have had a previous fusion procedure at the planned injection level. The injured worker had a clinical evaluation on 01/31/2014. The objective findings indicated tenderness to palpation of the lumbar spine. In addition, there was diminished sensation of the right L3, L4, L5 and S1 dermatome which is not consistent with facet originated pain according to the Official Disability Guidelines. In the discussion, it is documented that the medial branch block requested at L4-5 is for diagnostic purposes due to future consideration of a rhizotomy. The provider's request is for 2 medial branch blocks bilaterally at L4-5. However, the Official Disability Guidelines criteria specifically state 1 set of diagnostic medial branch blocks is required with a response of greater than 70%. Therefore, the request for 2 medial branch blocks bilaterally at L4-5 is not medically necessary.