

Case Number:	CM13-0059393		
Date Assigned:	12/30/2013	Date of Injury:	02/21/2009
Decision Date:	01/22/2015	UR Denial Date:	11/06/2013
Priority:	Standard	Application Received:	12/02/2013

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:

The injured worker is a 62-year-old male who reported an injury on 02/21/2009. The mechanism of injury was repetitive movements and lifting. The injured worker's diagnoses were noted to include lumbar radiculopathy, lumbar compression fracture, and chronic pain. The injured worker's past treatments included physical therapy, chiropractic therapy, acupuncture, and medications. The injured worker's diagnostic testing included an MRI of the lumbar spine performed on 05/07/2012 which was noted to reveal irregular contour seen at the endplates throughout the lumbar spine; a loss in vertebral body height at L2 by approximately 30%; 20% loss in vertebral body height of T12, L1, L3, and L5; mild endplate edema to the left of the midline at L2-3, likely Modic type I changes related to altered biomechanics. At L4-5, there was moderate central spinal canal stenosis with mild narrowing of the caudal margin of the neural foramina bilaterally. The injured worker's surgical history included a lumbar spine surgery in 02/2009 and in 2012. On 10/17/2013, the injured worker complained of low back pain that radiates to the left lower extremity. He rated a pain level of 6/10 with and without medications. He reported the pain as sharp, stabbing pain with difficulty bending. He reported difficulty with activities of daily living, including self-care, hygiene, ambulation, sleep, and sex. The injured worker reported a minimal overall improvement following a transforaminal epidural steroid injection at the left leg level on 10/03/2013. The injured worker reported significant functional improvement and improved mobility. Upon physical examination, the injured worker was noted with a slow gait with assistive device. The range of motion was noted to be moderately reduced in the lumbar spine secondary to pain. The range of motion of the lumbar spine was noted with flexion limited to 40 degrees and extension limited to 10 degrees. Pain was significantly increased with flexion, extension, and rotation. Spinal vertebral tenderness was noted to lumbar spine at the L4-S1 level. Lumbar myofascial tenderness and paraspinal muscle spasm was

noted on palpation. His sensory examination revealed decreased touch in the left lower extremity and right lower extremity. Motor examination revealed a moderate decrease in motor strength in the right lower extremity and left lower extremity. The injured worker was noted with positive facet signs. The injured worker's medications were not included in the documentation. The request was for bilateral L3-5 medial branch nerve blocks as a diagnostic trial to determine the origin of the injured worker's pain. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L3-L5 Medial Branch Nerve Block: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

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: The request for bilateral L3-5 medial branch nerve block is not medically necessary. The California MTUS/ACOEM Guidelines state that facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. More specifically, the Official Disability Guidelines recommend no more than 1 set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment. Diagnostic blocks may be performed with the anticipation that, if successful, treatment may proceed to the facet neurotomy at the diagnosed levels. The clinical presentation should be consistent with facet joint pain, to include tenderness to palpation of the paravertebral areas, absence of radicular findings, normal straight leg raise exam, and normal sensory examination. The diagnostic blocks are limited to injured workers with low back pain that is non-radicular and at no more than 2 levels bilaterally. There should be documentation of failure of conservative treatment, to include home exercise, physical therapy, and NSAIDs prior to the procedure for at least 4 to 6 weeks. The injured worker complained of low back pain that he rated a 6/10 on a pain scale with and without medications. He reported having completed physical therapy, acupuncture, medications, and epidural steroid injections with minimal to moderate relief. Upon physical examination, the injured worker was noted with positive facet signs, decreased sensation to touch in the left lower extremity and right lower extremity, and spinal vertebral tenderness was noted in the lumbar spine at the L4-S1 level. The injured worker reported minimal (5-20%) overall improvement post procedure, and reported moderate (20-50%) overall improvement. The injured worker reported significant functional improvement and improved mobility as a result of the transforaminal epidural steroid injection on 10/03/2013. The documentation did not provide sufficient evidence of tried and failed conservative treatment (to include physical therapy, home exercise program, and medications) prior to the requested procedure for at least 4 to 6 weeks. Furthermore, the injured worker was noted with an abnormal sensory examination, as decreased sensation to touch was noted in the left and right lower extremities. In the absence of documentation with sufficient evidence of tried

and failed conservative treatment and an abnormal sensory examination, the request is not supported at this time. As such, the request is not medically necessary.