

Case Number:	CM14-0196407		
Date Assigned:	12/03/2014	Date of Injury:	05/09/2001
Decision Date:	01/16/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/21/2014

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 Orthopedic Surgery and is licensed to practice in Texas. 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 an 80-year-old female who reported an injury on 05/09/2001. The mechanism of injury occurred when the patient was getting up from her desk. She tripped and fell. Diagnoses include lumbar radiculopathy, atrial fibrillation, and post lumbar laminectomy syndrome. The surgical history included a lumbar hemi-laminectomy at the L5-S1 in 1991. Medications included Lidoderm patch and Norco. The objective findings dated 10/16/2014 of the lumbar spine revealed a surgical scar. The range of motion was restricted with flexion limited to 20 degrees secondary pain. Extension limited to 0 degrees which was secondary to pain. On palpation, the paravertebral muscles were tenderness bilaterally. Spinous process with tenderness was noted at the L4-5. Lumbar facet loading was positive about the left. Straight leg raise test was positive on the right. Motor examination revealed the EHL at 4/5 on the right, 4+/5 on the left. Sensory examination revealed normal touch, pain, temperature, deep pressure, vibration intact, tactile localization, and tactile discrimination. Reflexes were within normal limits. Prior treatments included epidural steroid injections with 80% relief that was dated 08/14/2012. The treatment plan included 1 bilateral medial branch block at the L4, L5, and S1. The request for authorization dated 10/22/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Bilateral medial branch block at L4, L5 and S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

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

Decision rationale: The request for 1 bilateral medial branch block at L4, L5 and S1 is not medically necessary. The California MTUS/ACOEM Guidelines state diagnostic and/or therapeutic injections may have benefited an injured worker presenting in the transitional phase between acute and chronic pain. The ODG further state that criteria for use of diagnostic blocks is limited to injured workers with pain that is non-radicular, no more than 2 joint levels are injected in 1 session, and failure of conservative treatment to include home exercise, PT, and NSAIDs prior to the procedure for at least 4 to 6 weeks. The provider noted lumbar spine tenderness; however, it was not specifically over the L4, L5, and S1 regions. The documentation also indicated that the injured worker receives relief with her medication, noting 5/10 using the VAS. Therefore, indicating there is no failed conservative care. The injured worker continues to do her home exercise programs. Therefore, the request for the 1 bilateral medial branch block at L4, L5 and S1 is not medically necessary.