

Case Number:	CM14-0202993		
Date Assigned:	12/15/2014	Date of Injury:	11/19/2011
Decision Date:	02/03/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	12/04/2014

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 and Rehabilitation 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:

This 52 year old male sustained a work related injury on 11/19/2011. According to an Agreed Qualified Medical Evaluation dated 06/28/2014, the injury occurred while stringing a cable from a power pole to a house when he pulled something in his back while twisting and pulling the cable. As of a progress report dated 07/22/2014, the injured worker complained of constant aching low back pain. He could walk variable distances depending on his level of pain (anywhere from 1 block to a mile). There were no symptoms of his legs giving away and no bowel or bladder incontinence. Neck pain was rated a 3 on a scale of 0-10 and back pain was rated a 6. Symptoms were exacerbated by sitting, bending forwards, bending backwards, walking and standing. Symptoms were alleviated by lying down. Medications included ibuprofen at bed time. Prior treatments have included physical therapy, medication and chiropractic care. Work status was noted as unrestricted duty. Work intensity was described as light labor. Physical examination revealed motor iliopsoas 5/5, quadriceps 5/5, tibialis anterior 5/5, extensor hallucis longus 5/5, gastroc-soleus 5/5; sensory L2, L3, L4, L5 and S1 normal; reflexes patellar 1+/1+, and ankle 1+/1+, Babinski absent. The injured worker had a normal based gait. Straight leg raise was negative. Plan of care included physical therapy, MRI and CT scan of the lumbar spine and a follow up to review the MRI. According to the progress notes, symptoms were getting worse. According to an MRI report of the lumbar spine dated 09/09/2014, the injured worker had undergone fusion and posterior decompression of the L3 through S1 levels without overt evidence of postoperative complication. Otherwise multilevel degenerative disc disease was again seen with lessening of the posterior protrusion/extrusion at L2-3 with a residual mild central spinal canal stenosis. There was also persistent severe bilateral foraminal stenosis at L5-S1. On 09/15/2014 computed tomography imaging of the lumbar spine revealed posterior fusion of L3 through S1 with laminectomy decompression at L4 and L5 and

L5-S1 discectomy. Hardware appeared appropriately positioned without failure. There was adjacent level degenerative change at L2-3 with associated moderate central canal narrowing and disc annular calcification, persistent moderate neural foraminal narrowing at L5-S1 with associated spondylolisthesis and dorsal paraspinal muscle edema in the surgical bed, cannot exclude a component of myositis. As of a progress note dated 09/30/2014, physical examination revealed no gross neurological deficits identified in the myotomes or dermatome of the upper and lower extremities. Gait was within normal limits. According to the provider, the injured worker had lumbar degenerative disc disease, lumbar facet arthropathy. He is status post L3-S1 decompression and fusion. Symptoms were getting worse. The provider's impression was that facet blocks would help. On 11/13/2014, Utilization Review non-certified the request for bilateral L2-3 facet block. The request was received on 11/07/2014. According to the Utilization Review physician the injured worker's clinical presentation was not consistent with a facet joint pathology. The only objective finding noted on examination was the presence of an incisional scar and the rest of the examination was unremarkable. Tenderness to palpation in the paravertebral areas over the facet region was not documented. ACOEM generally does not recommend facet point injections. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L2-3 facet blocks 62311: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: The ACOEM Practice Guidelines, Chapter 12 Low Back Complaints, section Physical Methods states, facet blocks are not recommended except as a diagnostic tool as there is minimal evidence for treatment and current evidence is conflicting as to this procedure. At this time, guidelines do not recommend more than one therapeutic intra-articular block with positive significant pain relief and functional benefit for duration of at least 6 weeks prior to consideration of possible subsequent neurotomy. Facet blocks are not recommended in patients who may exhibit diffuse paraspinal tenderness symptoms without documented failed conservative trial. It is unclear what response resulted from physical therapy or other conservative treatment modalities. There are no clear symptoms and clinical findings specific of significant facet arthropathy with correlating MRI results showing degenerative changes and spinal stenosis without clear facet arthropathy. Submitted reports have not demonstrated support outside guidelines criteria. Therefore, this request is not medically necessary.