MAXIMUS Federal Services

Case Number:	CM14-0206255		
Date Assigned:	12/18/2014	Date of Injury:	12/22/2012
Decision Date:	02/09/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	12/09/2014

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 Rehab, has a subspecialty in Interventional Spine Pain Management 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 patient is a 59 year old female with an injury date of 12/22/12. Based on the 11/03/14 progress report the patient complains of back pain, difficulty sitting and standing at work, and bilateral foot pain. She feels that the neuroma in her left foot has gotten bigger and is causing some compression in her toes and it is uncomfortable to wear shoes. On physical examination she has stiffness and spasm of the lower lumbar spine, mechanical pain with the trunk rotation and flexion, and decreased sensation in the left L4-L5 and L5-S1. Upon examination of the bilateral feet, she has some tenderness over the calcaneus in the right foot and burning sensation on the top of the left foot. She is ambulating with a limp. The 10/20/14 MRI of the lumbar spine revealed that there is mild to moderate bilateral facet degenerative changes at L4-L5 with grade I anterolisthesis of L4 over L5 and severe disc space narrowing at L5-S1 with bilateral facer degenerative changes and endplate changes. There is a 2-3mm disc bulge with grade I anterolisthesis of L5 over S1. The patient's diagnoses includes the following: 1) Lumbar spine L5-S1 severe degenerative disc disease and facet arthropathy with bilateral neural foraminal stenosis causing left sided radiculopathy 2) Left sided possible mortons' neuroma 3) Right foot plantar fasciitis 4) Weight gain and non-orthopedic issues outside my area of specialty 5) T12 compression fracture preexisting from an equestrian riding injury. The utilization review determination being challenged is dated 12/04/14. Treatment reports were provided from 11/03/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L4-5 and L5-S1 lumbar facet injections: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Low Back Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic Chapter, Facet joint diagnostic blocks (injections).

Decision rationale: The patient presents with back pain, difficulty sitting and standing at work, and bilateral foot pain. The request is for a bilateral L4-5 and L5-S1 Lumbar Facet Injections. The records do not show any previous facet injections to the lumbar spine. The ACOEM guidelines do not support facet injections for treatment but does discuss dorsal medial branch blocks as well as radiofrequency ablations. ODG guidelines also support facet diagnostic evaluations for patients presenting with paravertebral tenderness with non-radicular symptoms, negative SLR and sensory examination. No more than 2 levels bilaterally are recommended. The 10/20/14 MRI of the lumbar spine revealed that there is mild to moderate bilateral facet degenerative changes at L4-L5 with grade I anterolistesis of L4 over L5 and severe disc space narrowing at L5-S1 with bilateral facer degenerative changes and endplate changes. There is a 2-3mm disc bulge with grade I anterolisthesis of L5 over S1. The 11/03/14 report states that the patient has back pain, difficulty sitting and standing at work, and bilateral foot pain. On physical examination she has stiffness and spasm of the lower lumbar spine, mechanical pain with the trunk rotation and flexion, and decreased sensation in the left L4-L5 and L5-S1. It does not appear as though the patient had any previous facet injections to the lumbar spine. ODG guidelines support facet diagnostic evaluations for patients presenting with paravertebral tenderness with non-radicular symptoms. In this case, the patient has neural foraminal stenosis at L5-S1 causing left sided radiculopathy, sensory changes on exam for which facet evaluation is not supported ODG Guidelines. Therefore, the requested lumbar facet injection is not medically necessary.