

Case Number:	CM14-0207414		
Date Assigned:	12/19/2014	Date of Injury:	03/03/2010
Decision Date:	02/11/2015	UR Denial Date:	12/05/2014
Priority:	Standard	Application Received:	12/11/2014

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 Interventional spine 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 50 year old male with an injury date of 03/03/10. Per physician's progress report dated 11/11/14, the patient complains of neck and low back pain with neck being the main area of concern. The pain and the function are rated at 7/10. The neck pain is greater on left than right. Physical examination reveals occiput tenderness, cervical spondylosis, and headaches. The patient also suffers from lumbar spondylosis and disc degeneration at L4-5 and L5-S1. The pain is greater on extension than flexion. In progress report dated 11/06/14, the patient complains of severe pain and spasm in the low back and neck. Physical examination reveals tenderness to palpation in the cervical paraspinal musculature along with spasms in the bilateral trapezial areas. Range of motion is limited and painful. Physical examination of the lumbar spine reveals tenderness in the paraspinal area along with spasm in the lower lumbar region. Straight leg raise is positive bilaterally and range of motion is limited and painful. There is decreased sensation in the right deltoid muscle and bilateral lateral thighs. Medication helps control the pain and keep the patient working, as per progress report dated 11/11/14. They include Exalgo ER, Flector, Meloxicam, Percocet and Soma. The patient is working with restrictions, as per progress report dated 11/11/14. MRI of the Cervical Spine, 07/09/12, as per progress report dated 11/11/14: Marked artifact from C5-6 fusion MRI of Lumbar Spine, 06/22/09, as per progress report dated 11/11/14:- Annular disc bulge with right-sided annular tear and mild left-sided foraminal narrowing at L4-5- Annular disc bulge with inferior extrusion at L5-S1 Diagnoses, 11/11/14:- Degenerative cervical intervertebral disc- Cervicalgia- Brachial neuritis/radiculitis- Cervical spondylosis- Lumbago- Thoraco / lumbosacral neuritis/radiculitis- Degenerative lumbosacral intervertebral disc The treater is requesting for LUMBAR MEDIAL BRANCH BLOCK AT

THE BILATERAL L3, L4 AND L5 LEVELS. The utilization review determination being challenged is dated 12/05/14. Treatment reports were provided from 06/19/14 - 11/11/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Medial Branch Block at the bilateral L3, L4, and L5 levels: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back and Medial branch block

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 (Acute & Chronic)' chapter and topic 'Facet joint medial branch blocks (therapeutic injections).'

Decision rationale: The patient presents with neck and lower back pain rated at 7/10, as per progress report dated 11/11/14. The request is for LUMBAR MEDIAL BRANCH BLOCK AT THE BILATERAL L3, L4 AND L5 LEVELS. ODG Guidelines, 'Low Back - Lumbar & Thoracic (Acute & Chronic)' chapter and topic 'Facet joint medial branch blocks (therapeutic injections)', state that: 1) Tenderness to palpation in the paravertebral areas (over the facet region); (2) A normal sensory examination; (3) Absence of radicular findings, although pain may radiate below the knee; (4) Normal straight leg raising exam. The ACOEM guidelines, chapter 12, state "Repeated diagnostic injections in the same location(s) are not recommended." A review of the available progress reports does not indicate prior facet joint injections or medial branch blocks. As per progress report dated 11/06/14, the patient has tenderness in the paraspinal muscles. However, the same progress report states that the patient has positive straight leg raise bilaterally and has been diagnosed with bilateral L5 radiculopathy. There is decreased sensation in the right deltoid muscle and bilateral lateral thighs. Another progress report dated 11/11/14 also states that the patient had lumbosacral radiculitis. ODG does not support facet joint evaluation when there are sensory findings and/or radicular symptoms. The request IS NOT medically necessary.