

Case Number:	CM15-0009035		
Date Assigned:	01/27/2015	Date of Injury:	11/16/2010
Decision Date:	03/24/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/15/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 38-year-old male who reported injury on 11/16/2010. The mechanism of injury was a fall. Prior studies included an MRI of the lumbar spine without contrast with 2 view chest x-ray. The surgical history included a right L4-5 discectomy in 05/2008. Prior therapies included physical therapy and epidural steroid injections. On 07/06/2011, the injured worker underwent an L4-5 posterior lumbar interbody fusion with pedicle screw instrumentation. The documentation of 12/15/2014 revealed the injured worker had continued back pain with radiation to the lower extremities, buttocks, calf, and was worse on the left leg. The injured worker indicated the left leg gave out on him. The injured worker was utilizing several Norco per day with minimal relief. The injured worker was noted to have an MRI of the lumbar spine which revealed postoperative changes noted at L4-5. There was mild bilateral foraminal narrowing at L5-S1 with facet arthropathy. There was diffuse disc bulge, 3 mm at L5-S1. The physical examination revealed diminished light touch in the left lateral extremity. The injured worker's lower extremity strength on the left was dorsiflexion and plantar flexion of 4/5. The injured worker had moderate to severe tenderness to palpation of the mid lumbar spine. The gait was slow. The diagnoses included failed back syndrome, lumbar disc degeneration, and lumbar facet arthropathy. The treatment plan included facet injections at L5-S1 bilaterally and epidural steroid injections for both diagnostic and therapeutic purposes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Facet Injection @ L5-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Facet joint diagnostic blocks (injections) Facet joint medial branch blocks (therapeutic injections), Facet Joint Pain, Signs and Symptoms

Decision rationale: The American College of Occupational and Environmental Medicine Guidelines indicate that a facet neurotomy (Rhizotomy) should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As the American College of Occupational and Environmental Medicine does not address specific criteria for medial branch diagnostic blocks, secondary guidelines were sought. The Official Disability Guidelines indicate that a medial branch block is not recommended except as a diagnostic tool; minimal evidence for treatment. The criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings although pain may radiate below the knee, and a normal straight leg raise exam. There should be documentation of failure of conservative treatment including home exercise, physical therapy, and NSAIDS prior to the procedure for at least 4 to 6 weeks and no more than 2 facet joint levels should be injected in 1 session. Additionally, one set of diagnostic medial branch blocks is required with a response of 70%, and it is limited to no more than 2 levels bilaterally and they recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered under study). The clinical documentation submitted for review indicated the injured worker had tenderness to palpation of the paravertebral area. However, there was a lack of documentation of a normal sensory examination and the absence of radicular findings. There was a lack of documentation of a normal straight leg raise. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for lumbar facet injection at L5-S1 is not medically necessary.