

Case Number:	CM15-0146662		
Date Assigned:	08/07/2015	Date of Injury:	12/23/1996
Decision Date:	09/03/2015	UR Denial Date:	07/17/2015
Priority:	Standard	Application Received:	07/28/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 (IW) is a 51-year-old male who sustained an industrial injury on 12-23-1996. Diagnoses include lumbosacral spondylosis without myelopathy. Treatment to date has included medications, spinal fusion (10-22-2012), heat, ice, home exercise and physical therapy. According to the Final Report dated 7-14-2015, the IW reported recurrent onset of low back pain beginning six months prior to this visit. The pain was midline in the low back with occasional spasms. The pain was worse with sitting and standing. Lying down relieved the pain by 75%. He denied any radicular symptoms and leg weakness. On examination, there was restricted forward flexion, but mostly extension of the lumbar spine. He had 4 over 5 strength in the iliopsoas bilaterally due to pain and 5 over 5 strength in the quadriceps, tibialis anterior, EHL and gastrocnemius, bilaterally, within the limits of his ankle fusion. Sensation was intact to light touch from L2 to S1 bilaterally. An MRI of the lumbar spine on 7-12-2015 showed interbody fusion at L4-5 and L5-S1 with degenerative disc disease most prominent at L1-L2 with left paramedian disc protrusion contacting and minimally displacing the traversing left L2 nerve root without central spinal canal or neural foraminal stenosis at any level. A request was made for lumbar facet block to the bilateral L3-4 level to treat the IW's progressive pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Facet Block: 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): 301-308.

Decision rationale: The ACOEM chapter on low back complaints states: Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain. Per the ODG, facet joint injections are under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are currently not recommended as a treatment modality in most evidence based reviews as their benefit remains controversial. The requested service is not recommended per the ACOEM or the Official Disability Guidelines. Therefore, the request is not medically necessary.