Case Number:	CM15-0212012		
Date Assigned:	10/30/2015	Date of Injury:	04/24/2012
Decision Date:	12/11/2015	UR Denial Date:	10/01/2015
Priority:	Standard	Application Received:	10/27/2015

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: Texas, Florida, California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 female who sustained an industrial injury on 04-24-2012. According to an initial consultation report dated 09-08-2015, the injured worker reported low back pain radiating down the legs into the lateral thighs, left and right alternating. Pain was rated 4 out of 10 with medication and 8 without medication. Current medications included Vicodin and Norco. MRI of the lumbar spine performed on 06-08-2012 showed straightening of normal lordotic curvature, disk desiccation with suggestion of an annular fissure and 8 mm of central posterior disk protrusion-extrusion causing pressure over the anterior aspect of the thecal sac. The disk was noted to be indenting both sacroiliac joint nerves. X-rays of the lumbar spine performed on 09-08-2015 showed mild disc height narrowing L5-S1, mild to moderate facet arthropathy L5-S1, no instability, and no fracture. Physical examination demonstrated palpable tenderness over the L5-S1 region bilaterally, pain with extension and left lateral bending improved with forward flexion and right lateral bending. Straight leg raise was negative. Sensory was intact with light touch and pinprick to the bilateral lower extremities. Assessment included chronic lumbago, L5-S1 facet arthropathy per x-ray and examination and L5-S1 disc degeneration. The provider noted that the injured worker had low back pain without radiculopathy, increased pain with extension that improved with forward flexion and evidence of facet arthritis on oblique x-rays of the lumbar spine. The treatment plan included facet blocks at L5-S1 bilaterally; radiofrequency ablation if diagnostic, electrodiagnostic studies of the lower extremities and a follow up after the facet blocks. The injured worker was temporarily partially

disabled. On 10-01-2015, Utilization Review non-certified the request for facet blocks at L5-S1 bilaterally and authorized the request for electrodiagnostic studies of the lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Facet blocks at L5-S1 bilaterally: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

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 under Medical Branch Blocks, Diagnostic.

Decision rationale: This claimant was injured in 2012 and has low back pain with radiation. X-rays showed mild facet arthropathy. The pain worsened with extension of the back, which is a classic facet sign, but there was also a radicular pain distribution. The surgical plans in this claimant is also not clear. The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. The ODG notes: Criteria for the use of diagnostic blocks for facet mediated pain: 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 joint levels are injected in one session (see above for medial branch block levels). 5. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 6. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. It is not clear if medial branch blocks vs. intra-articular facet blocks are proposed. Also, I would agree with the previous UR that the electrodiagnostics should be first done to truly rule out radiculopathy, but hold on the facet injections until radiculopathy had been ruled out. The request is appropriately not medically necessary.