

Case Number:	CM15-0221360		
Date Assigned:	11/16/2015	Date of Injury:	08/23/2013
Decision Date:	12/30/2015	UR Denial Date:	10/26/2015
Priority:	Standard	Application Received:	11/10/2015

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: 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:

This is a 61 year old male with a date of injury on 8-23-2013. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar strain with right L4-L5 disc herniation with bilateral neural foraminal encroachment and central stenosis, lumbar facet syndrome and left sided femoral cutaneous neuralgia. According to the progress report dated 10-7-2015 the injured worker reported being able to stand for ten minutes before needing to sit because of left lateral leg pain as well as axial low back pain. The physical exam (10-7-2015) revealed reduced range of motion in the lumbar spine. Facet loading maneuvers reproduced concordant baseline axial low back pain bilaterally. There was positive paravertebral tenderness to palpation adjacent to the inferior lumbar facet joints. Per the progress report dated 10-21-2015, the injured worker continued working and experienced varying degrees of low back pain with radicular symptoms into his lower extremities. Objective findings (10-21-2015) revealed moderate, bilateral paralumbar tenderness extending into the sciatic notch on the left. Treatment has included physical therapy, lumbar support and medication (Neurontin and Ultram). The physician noted (10-7-2015) that magnetic resonance imaging (MRI) of the lumbar spine showed facet joint effusions at the L5-S1 facets and facet arthropathy was noted in the L4-L5 and L5-S1 facet joints bilaterally. The treatment plan was for bilateral L4 and L5 medial branch blocks, which would be diagnostic in nature and would inform candidacy for possible radiofrequency ablation. The original Utilization Review (UR) (10-26-2015) denied a request for bilateral L4 and L5 medial branch blocks under fluoroscopic guidance.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Bilateral L4-L5 Medial Branch Block under fluoroscopic guidance: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Facet Joint Diagnostic Blocks (Injections).

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

Decision rationale: According to ODG, Facet joint diagnostic blocks (injections) are recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment. Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). According to ODG's section on facet joint pain, signs & symptoms. physical exam findings & symptoms: As most examinations simultaneously test several structures including muscles, ligaments, discs and facets, there is no suggested physical maneuver or tests to effectively diagnose facet joint mediated pain. Axial low back pain is generally present with lumbar paravertebral tenderness. There is no reliable pain referral pattern other than that pain is "pseudoradicular." It is suggested that pain from upper facet joints tends to extend to the flank, hip and upper lateral thighs, while the lower joint mediated pain tends to penetrate deeper into the thigh (generally lateral and posterior). Infrequently, pain may radiate into the lateral leg or even more rarely into the foot, although multiple references indicate pain distal to the knee is rarely associated with facet joint pathology. In the presence of osteophytes, synovial cysts (diagnosed with MRI) or facet hypertrophy (diagnosed on imaging), radiculopathy may also be present. In patients with these latter conditions, injection therapy will generally not alleviate pain that originates primarily from the anterior or posterior ligaments or bone. The medical records indicate that the injured worker may have fact mediated pain. The injured worker has not responded to conservative therapy and as such the requested medial branch block for diagnostic purposes to determine if the injured worker is a candidate for radiofrequency ablation is supported. The request for 1 Bilateral L4-L5 Medial Branch Block under fluoroscopic guidance is medically necessary and appropriate.