

Case Number:	CM15-0224492		
Date Assigned:	11/20/2015	Date of Injury:	10/29/2014
Decision Date:	12/31/2015	UR Denial Date:	11/05/2015
Priority:	Standard	Application Received:	11/16/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 59-year-old male who sustained a work-related injury on 10-29-14. Medical record documentation on 10-21-15 revealed the injured worker was being treated for lumbar herniated nucleus pulposus, lumbar radiculopathy and lumbar L5 spondylosis. He reported persistent and unchanged symptoms but noted improvement with his right leg complaints. He reported continued pain in the low back and did not experience relief. He rated his low back pain a 9 on a 10-point scale and had radiating numbness into the right buttock. He reported occasional spasms in the low back. His previous treatment included 3 sessions of physical therapy with no relief, lumbar transforaminal epidural steroid injection to the right L4, L5, and S1 on 9-10-15 with no relief to the low back and significant relief to the right leg, 8 sessions of chiropractic therapy with no relief, TENS unit with no relief, Naproxen 550 mg, Advil with minimal relief, Tylenol with codeine with no relief, Percocet 10-325 mg with good relief and topical cream with no relief. Objective findings included a mildly antalgic gait. He had tenderness to palpation of the lumbar spine with spasms noted and had a positive facet challenge to the bilateral L5-S1 facets. He had tenderness to palpation of the lumbar L5-S1 facets. His lumbar spine range of motion included flexion to 30 degrees, extension to 10 degrees, and bilateral lateral bending to 10 degrees. His sensation was intact in the bilateral lower extremities. A straight leg raise bilaterally caused back pain only. The evaluating physician documented an MRI of the lumbar spine on 6-26-15 as revealing grade 1 anterolisthesis at L5-S1 with possible L5 spondylosis and L5-S1 central protrusion-extrusion slightly contacts the S1 nerve root. An EMG-NCV of the bilateral lower extremities on 5-4-14 is documented as revealing evidence suggestive of bilateral S1

radiculopathy. A request for medial branch block to the bilateral L5-S1 facets was received on 11-2-15. On 11-5-15, the Utilization Review physician determined medial branch block to the bilateral L5-S1 facets was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial Branch Block to the Bilateral L5-S1 Facets: Overturned

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, Facet Joint Intraarticular Injections.

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), Diagnostic facet joint blocks (injections).

Decision rationale: The claimant sustained a work injury in October 2014 when he felt a pop in his low back while moving bundles of wood. Treatments include medications, physical therapy, and chiropractic care without reported benefit. Right transforaminal epidural steroid injections were done in September 2015. When seen in October 2015 there had been improvement in his right leg complaints. He was having ongoing low back pain. He had pain rated at 9/10. There was radiating numbness to the right buttock and occasional spasms. There was decreased lumbar range of motion. There was facet tenderness with positive facet challenge at L5/S1. There was low back pain with straight leg raising. There was normal sensation with decreased strength with testing limited by pain. Imaging results were reviewed with findings of multilevel spondylosis and positive L5 spondylolysis. Medial branch blocks at L5/S1 were requested. Criteria for the use of diagnostic blocks for facet mediated pain include patients with low-back pain that is non-radicular and where there is documentation of failure of conservative treatments. No more than two facet joint levels are to be injected in one session. In this case, the claimant has low back pain without lower extremity radicular pain symptoms. Physical examination findings are consistent with facet mediated pain. A single level is being requested and conservative treatments have been extensive and of limited benefit. The requested medial branch block procedure is considered medically necessary.