

<b>Case Number:</b>	CM15-0087658		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	01/15/2014
<b>Decision Date:</b>	06/16/2015	<b>UR Denial Date:</b>	04/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2015

### 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: 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 51 year old male, who sustained an industrial injury on January 15, 2014. The injured worker reported back pain. The injured worker was diagnosed as having lumbar facet arthropathy, spondylosis and possible radiculopathy. Treatment and diagnostic studies to date have included medication, chiropractic and physical therapy. A progress note dated March 30, 2015 provides the injured worker complains of back pain rated 7-9/10. Physical exam notes lumbar tenderness on palpation with decreased range of motion (ROM). The plan includes medial branch block, reevaluation and medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LT L4 and L5 Diagnostic Medial Branch Block x 1:** 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.

**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) Section.

**Decision rationale:** Per the MTUS Guidelines, facet-joint injections are of questionable merit. The treatment offers no significant long-term functional benefit, nor does it reduce the risk for surgery. This request is for diagnostic blocks, which are not addressed by the MTUS Guidelines. The ODG recommends no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment. The clinical presentation should be consistent with facet joint pain, signs and symptoms. The procedure should be limited to patients with low-back pain that is non-radicular and no more than two levels bilaterally. There should be documentation of failure of conservative treatment, including home exercise, physical therapy and NSAIDs for at least 4-6 weeks prior to the procedure. No more than two facet joint levels should be injected in one session. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated or in patients who have had a previous fusion procedure at the planned injection level. In this case, a previous MRI revealed a pars defect at L5 bilaterally with resultant spondylolisthesis which are the probable cause of the injured workers pain. Additionally, an EMG revealed chronic left L5 radiculopathy. The request for LT L4 and L5 Diagnostic Medial Branch Block x 1 is determined to not be medically necessary.

**Re-evaluation with MD:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Office Visits.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177, 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back/Office Visits.

**Decision rationale:** The MTUS Guidelines do not address office visits specifically for chronically injured workers. The MTUS Guidelines recommend frequent follow-up for the acutely injured worker when a release to modified, increased, or full activity is needed, or after appreciable healing or recovery can be expected, on average. Per the ODG, repeat office visits are determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The injured worker has a chronic condition and is not showing evidence of improvement with conservative treatments. This request for follow-up is for the period after the requested facet- joint branch block. The facet-joint branch block was not determined to be medically necessary, therefore, the request for Re-evaluation with MD is determined to not be medically necessary.