MAXIMUS Federal Services

Case Number:	CM13-0068079		
Date Assigned:	01/03/2014	Date of Injury:	01/27/2004
Decision Date:	07/15/2014	UR Denial Date:	12/12/2013
Priority:	Standard	Application Received:	12/19/2013

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. The expert reviewer is Board Certified in Internal Medicine, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 59-year-old who was injured on January 27, 2014 when she was trying to lift her assigned client by wheelchair up over a curb. She suffered pain which occurred in her right leg which had gone through her right buttock. She later had another injury which occurred while lifting the same client, this time while bending at the waist. She had pain at that time with the second injury in the upper back which radiated into the base of her neck and then radiated from her neck into her arms. The lower extremity pain also increased with that particular injury. A third injury was sustained on January 31, 2004 when she tried to continue working and was trying again to maneuver the client by wheelchair up a ramp. Her diagnoses are diagnoses are DDD (degenerative disc disease) and DJD (degenerative joint disease) at the cervical spine from C4 to C6-7 with the maximum being seen at C-6; DDD and DJD of the lumbar spine at multiple levels; chronic low back and cervical spine pain; and posterolateral disc extrusion at the L4-5 level, measuring 3 mm in diameter with impingement on the exiting L4 nerve root per MRI study. Prior treatment history has included chiropractic care, physical therapy with no benefit; medications including Norco and Flexeril; trigger point injections and epidural steroid injections. She also received acupuncture therapy which offered no sustained relief. The patient underwent bilateral foraminotomies, medial facetectomies, and microdiscectomy to L5-S1 on April 25, 2007. Diagnostic studies reviewed include CT of the lumbar spine without contrast dated June 19, 2012 shows an interval discectomy and bone graft placement with solid osseous fusion at the L5-S1 level; laminectomy changes; posterior fusion without evidence of instrumentation failure; spondylosis causing mild spinal stenosis at the L4-5 and L3-4 levels; and foraminal stenosis/listhesis. MRI of the lumbar spine dated 04/06/2012 reveals evidence of lumbar fusion from L5-S1 and an L4-5 disc protrusion appeared to impinge L4 nerve root and left L4-5 foramen as well as scar tissue around the S1 nerve root. CT of the lumbar, 2 views, dated November 29, 2011 show no significant interval change in L5-S1 at the level of fusion.

Myelogram of the lumbar spine dated December 23, 2009 reveals a slight 2 mm motion at L3-L4 level on upright flexion and extension views; deformity is noted at L3-4, L4-5, and L5-S1 levels. There is diminished filling of both L5 and left L4 nerve sleeves. There is no evidence of clumping of the nerves within the thecal sac. Orthopedic clinic note dated November 5, 2013 states the patient presents with a new onset of low back pain with recurrence of all of the previously described symptoms. The patient has a urine drug screen on April 4, 2013, which showed Tramadol in the urine but no Soma, or Amitriptyline. Urine drug screen dated January 10, 2013 did not reveal any nonprescription medications. At this time she was taking Naproxen, Norco, Amitriptyline and Methocarbamol; and results were consistent with prescribed medications. Urine toxicology screen dated March 29, 2012 showed the prescribed medications Cyclobenzaprine and Amitriptyline. Oxycodone was also found to be positive. On exam, range of motion of the neck exhibits extension to 40 degrees. She is able to forward flex to touch her chin to her chest; and extension to 40 degrees; Range of motion of the upper extremities exhibits decreased range of motion in the shoulder extension at 40 degrees on the right; flexion to 140 bilaterally; adduction to 50 bilaterally; external rotation to 70 bilaterally; and internal rotation to 90 on the right and 80 on the left. Muscle strength is 5/5 in all muscle groups bilaterally; Supinator and pronator are normal at 5/5 bilaterally. Deep tendon reflexes are 2+ bilaterally except on the left triceps which is 1+. The back and lower extremities reveal no evidence of scoliosis. There is normal kyphosis and lordosis, but she had tenderness from T8 down to L5-S1 with muscle spasm equal bilaterally from about T10 to L5-S1. There was a scar from the mid-lumbar region, which measured about 12 cm and an abdominal scare of about 10 cm. Both of these were well healed and showed no complicating features. Muscle spasm was found to be present from T10 to L5-S1 as previously noted which was worse on the left than on the right. Range of motion of the back exhibits extension to 4 degrees; flexion to 17 degrees; lateral bend/right to 19 degrees and lateral bend/left to 16 degrees. Patellar reflexes are 2+ bilaterally; Achilles is 1+ on the right and is no producible even with recruitment on the left. Babinski's sign is bilateral down going; sensation to pinwheel testing is decreased over the right VMO area of the distal thigh and also medial calf. The treating provider has requested outpatient medicalbranch blocks at bilateral L3-4 and L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

OUTPATIENT MEDIAL BRANCH BLOCKS (MBB) AT BILATERAL L3-4 AND L5-5: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 (Acutea and Chronic), Facet joint diagnostic blocks (injections) & Facet joint pain, signs & symptoms.

Decision rationale: The ODG recommends suggested indicators of pain related to facet joint pathology as follows: (1) Tenderness to palpation in the paravertebral areas (over the facet region); (2) A normal sensory examination; (3) Absence of radicular findings, although pain may radiate below the knee; (4) Normal straight leg raising exam. Indictors 2-4 may be present if there is evidence of hypertrophy encroaching on the neural foramen. The medical records document the patient underwent a spinal fusion and post surgical CT scan indicate patient has had fascetectomies at aL3-4 and had a fusion at L5-S1 Further, the documents show significant tenderness over the lumbar spine and the diagnostic median branch blocks are a reasonable request. She has failed conservative therapy with medications including opiates, physical therapy, and chiropractic therapy. Based on the ODG guidelines and criteria as well as the clinical documentation stated above, the request is within guidelines. Medical necessity for the requested service has been established. The request for outpatient MBB at bilateral L3-L4 and L5-5 is medically necessary and appropriate.

FOLLOW UP OFFICE VISIT: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 and Chronic), Office visits.

Decision rationale: CA MTUS do not specifically discuss the issue and hence ODG have been consulted. The ODG recommends a follow-up visit after diagnostic median nerve blocks are necessary to evaluate the results of the diagnostic blocks. The medical records document the assessment of diagnostic median nerve blocks as medically necessary. Therefore, the request for a follow up office visit is medically necessary and appropriate.