

Case Number:	CM14-0160625		
Date Assigned:	10/03/2014	Date of Injury:	07/25/2013
Decision Date:	10/30/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	09/29/2014

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 Orthopedic Surgery 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:

This 51-year-old male truck driver sustained an industrial injury on 7/25/13. Injury occurred relative to a truck rollover accident. Injuries were reported to the head, neck, lower back, both shoulders and the right arm. Records documented the presence of bilateral lower extremity radicular symptoms with provocative activities. The 7/14/14 nerve conduction study improvement documented a prolonged bilateral H-reflex which was not a specific finding and may be secondary to metabolic disorders versus S1 radiculopathy. Imaging correlation was recommended. The patient deferred needle EMG. The 7/16/14 lumbar spine MRI impression documented lumbar degenerative changes, with mild osteoarthritis of the L4/5 facet joints. There was a left L5 pars defect with associated stress related bone marrow edema in the left pedicles of L4 and L5 and a 3 mm grade 1 anterolisthesis of L5 on S1. The 9/16/14 treating physician report cited grade 7/10 left upper back, low back, and right greater than left shoulder pain. He reported benefit with a TENS unit. He continued to report nausea and headache with vomiting. He complained of bladder incontinence and intermittent bilateral great toe numbness. There was bilateral 4/5 hip flexion weakness with back pain, otherwise lower extremity strength was 5/5. Sensation was decreased over the left L5 dermatome. The diagnosis included lumbar spondylosis and myofascial pain syndrome. The treatment plan recommended referral for bilateral L3, 4, 5 medial branch blocks and L5 pars steroid injection. The 9/26/14 utilization review denied the request for lumbar medial branch blocks as there was a radicular component to the pain complaint and the request includes more than 2 joint levels.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right lumbar medial branch block #1, L3, L4, & L5, as an outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 187-190. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Facet joint intra-articular injections (therapeutic blocks), Facet joint medial branch blocks (therapeutic injections), Facet joint pain, signs & symptoms

Decision rationale: The California ACOEM Revised Low Back guidelines state that therapeutic facet joint injections are not recommended for acute, subacute, chronic lower back pain or for any radicular pain syndrome. One diagnostic facet joint injection may be recommended for patients with chronic lower back pain that is significantly exacerbated by extension and rotation, or associated with lumbar rigidity, and not alleviated with other conservative treatments, in order to determine whether specific interventions targeting the facet joint are recommended. Clinical presentation should be consistent with facet joint pain, signs and symptoms. No more than 2 joint levels may be blocked at any one time. Guideline criteria have not been met. Current clinical exam findings do not support a diagnosis of facet mediated pain. There is no documentation of tenderness over the facet region or documentation of a straight leg raise test. There is an abnormal sensation exam, myotomal weakness, and radicular complaints have been noted with provocative activities. The request exceeds guideline recommendations for blocks at no more than 2 levels. Therefore, this request is not medically necessary.