

Case Number:	CM14-0168476		
Date Assigned:	10/16/2014	Date of Injury:	12/11/2002
Decision Date:	11/18/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	10/13/2014

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 Pain Management, 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 injured worker is a 58 year old female with a date of injury on 12/11/2002. Per records dated 9/18/2014, the injured worker complained of low back pain described as aching, burning, dull, pressure-like and sharp. Pain radiates to the back and bilateral legs. She rated her pain as 8/10 and on average as 5/10. Pain was made worse with activity and movement. She also reported difficulty staying asleep due to pain, frustrations, muscle cramps, need for sleeping pills, numbness, recent sweats, sleep problems and depression. Previous treatments include physical therapy, acupuncture, and chiropractic care with no relief, transforaminal blocks at L5 with 95% relief as well as significant functional improvements and decreased medication use. However, she stated that she has different additional pain in the low back that radiates to the hips. Examination noted tenderness to the lumbar spine, positive facet loading and increase tone and pain to the lumbar paraspinals, compression of trigger point elicited local tenderness, referred pain, and local twitch response. Range of motion was limited in all planes. Straight leg raise test was positive with left L5 radiculopathy. Magnetic resonance imaging (MRI) of the lumbar spine dated 5/20/2010 noted multilevel central canal and bilateral recess stenosis due to combination of posterior discogenic abnormality, facet joint osteoarthritis, and ligamentum flavum redundancy, multi-level spondylosis and multilevel disc collapse. She is diagnosed with (a) lumbar/thoracic radiculopathy, (b) lumbar facet spondylosis, and (c) myofascial pain syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Diagnostic lumbar facet medial branch block under fluoroscopic guidance (2 levels): Upheld

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, Facet Joint Diagnostic Blocks (injections) and symptoms.

Decision rationale: According to the criteria for the use of diagnostic blocks for facet mediated pain the clinical presentation of the injured worker/injured worker should be consistent with facet joint pain, signs and symptoms, limited to injured workers with low-back pain that is non-radicular and no more than two levels bilaterally, and there is documentation of failure of conservative treatments (including home exercise, physical therapy (PT), and non-steroidal anti-inflammatory drugs [NSAIDs]) prior to procedure for at least 4-6 weeks. In this case, records indicate that although there is tenderness over the lumbar facet region radiculopathy is present on physical examination. Specifically, records indicate that low back pain radiates to the bilateral hips and legs. Moreover, straight leg raising testing was also positive to the left L5. Based on this clinical presentation does not satisfy the criteria for the use of diagnostic blocks for facet mediated pain. Therefore, the medical necessity of the requested bilateral diagnostic lumbar facet medial branch block under fluoroscopic guidance (2 levels) is not medically necessary.