

Case Number:	CM14-0092389		
Date Assigned:	09/19/2014	Date of Injury:	06/24/2013
Decision Date:	10/20/2014	UR Denial Date:	06/09/2014
Priority:	Standard	Application Received:	06/18/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 is a 30-year-old female patient with a 6/24/13 date of injury, when she sustained injuries to her low back and wrist secondary to a fall out of a chair. 7/24/14 progress report indicates constant 8/10 low back pain, increasing to 10/10 if the patient sits longer than 15 minutes. At times, the pain radiates to the left leg and the left foot. She also complains of tingling in the left foot. She is exhibiting impaired activities of daily living. Physical exam demonstrates limping gait, limited left foot elevation while toe walking. There is tenderness over the lumbosacral junctions bilaterally. Lumbar ROM is satisfactory. Motor, reflex, and sensory exam demonstrates unremarkable findings except for diminished sensation in the plantar aspect of the left foot. Lumbar X-rays demonstrate mild to moderate disc space narrowing at L5-S1. No osteophytes. 1/28/13 lumbar CT demonstrates, at L5-S1, a 2 mm right paracentral disc bulge causing no significant neural foraminal narrowing or canal stenosis. The facet joints are normal. 1/15/14 electrodiagnostic testing was positive for chronic left L4 radiculopathy. Treatment to date has included activity modification, electrical stimulator, chiropractic, lumbar support, pain medication injection, several lumbar ESI, physical therapy, and medication. There is documentation of a 6/9/14 adverse determination due to lack of physical therapy progress reports, and the presence of active radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral facet block L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG, Low back

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 Chapter, Medial Branch Blocks

Decision rationale: CA MTUS does not address this issue. ODG states that medial branch blocks are not recommended except as a diagnostic tool for patients with non-radicular low back pain limited to no more than two levels bilaterally; conservative treatment prior to the procedure for at least 4-6 weeks; and no more than 2 joint levels are injected in one session. The patient presents with ongoing significant low back pain complaints recalcitrant to prolonged attempts at activity modification, electrical stimulator, chiropractic, lumbar support, pain medication injection, several lumbar ESI, physical therapy, and medication. Physical exam demonstrates mostly negative neurologic findings, but subjective complaints and electrodiagnostic testing suggest active radiculopathy. However, specific provocative testing for facetogenic etiology of the patient's complaints was not documented on the most recent physical exam. Imaging reports were negative for degenerative facet joint changes. There are also discrepancies as to what procedure is requested specifically as the 7/24/14 report discusses facet injections, while the request, as submitted, would be for medial branch blocks. It also noted that a lumbar CT demonstrated a right-sided lesion while the patient complains of left-sided pain; and the EMG is consistent with left L4 radiculopathy. Her only physical findings were in the left L5 dermatome. Therefore, the request for a bilateral facet block L5-S1 was not medically necessary.