

Case Number:	CM15-0002244		
Date Assigned:	01/13/2015	Date of Injury:	05/21/2012
Decision Date:	03/16/2015	UR Denial Date:	12/11/2014
Priority:	Standard	Application Received:	01/06/2015

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, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care 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 60-year-old female who reported an injury on 05/21/2012. The mechanism of injury was due to a slip and fall. Her relevant diagnoses include L5-S1 lumbar degenerative disc disease and facet arthropathy and right knee surgery. Past treatments included surgery, wheelchair, medications and physical therapy. Her diagnostics included an unofficial lumbar x-ray, indicating degenerative disc and collapse at the L5-S1 level with no major instability or spondylolisthesis; an unofficial lumbar MRI showing degenerative disc disease at the L5-S1, with right greater than left facet arthropathy causing a mild degree of foraminal narrowing. On 11/19/2014, the injured worker complained of pain in her left foot and low back right of the midline, with associated symptoms of numbness and tingling and weakness in the lower extremities. A physical examination revealed tenderness to palpation in the right lumbar paraspinal muscles, increasing pain with extension past neutral. The injured worker was indicated to have a negative straight leg raise bilaterally. The injured worker was also indicated to not have any motor deficits to EHL and ankle dorsiflexion. The injured worker's hips were also indicated to move freely on the right. Her relevant medications included metoprolol, baclofen, Norco and nabumetone. The treatment plan included a lumbar spine bilateral L5-S1 facet block with sedation, to help diagnostically, as well as therapeutically, with hopes of making her rehab for her left knee more effective. A Request for Authorization form was submitted on 12/02/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar spine bilateral L5-S1 facet block with sedation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Diagnostic facet injections

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, Facet joint diagnostic blocks (injections).

Decision rationale: The request for lumbar spine bilateral L5-S1 facet block with sedation is not medically necessary. According to the California MTUS/ACOEM Guidelines, invasive techniques, such as local injections and facet injections are of questionable merit. More specifically, the Official Disability Guidelines indicate that facet joint diagnostic blocks are limited to patients with low back pain that is nonradicular and at no more than 2 levels bilaterally. There should also be documentation of failed conservative treatments including home exercise, PT and NSAIDs prior to the procedure for at least 4 to 6 weeks. In addition, the guidelines indicate that IV sedation may be grounds to negate the results of a diagnostic block and should not only be given in cases of extreme anxiety. The injured worker was indicated to have degenerative disc disease and facet arthropathy. However, there was a lack of documentation to indicate the injured worker had failed conservative treatments to include home exercise, PT and NSAIDs prior to the procedure for at least 4 to 6 weeks. In addition, there was a lack of documentation to indicate the patient had extreme anxiety to indicate medical necessity for use of IV sedation. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.