

Case Number:	CM14-0143564		
Date Assigned:	09/12/2014	Date of Injury:	04/10/2014
Decision Date:	10/15/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/04/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain 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 50-year-old female housekeeper who sustained an industrial injury on 4/10/2014. While pulling a heavy container she felt sudden pain in the right side of her paraspinal muscles. She has completed at least 6 PT sessions. The 6/4/2014 lumbar MRI reveals multilevel mild degenerative disc disease. The 8/21/2014 PR-2 documents the patient complains of pain on both sides of the back, more on the right. She feels a small amount of pain in the right leg. She denies numbness/tingling. She has done PT, which only helped a little with her walking. She has not tried other treatment. She is completely off work now. Pain is rated 6/10. Response to injection therapy - unchanged. Examination reveals tenderness of L5 and S1, limited active lumbar flexion and extension due to pain, normal neurological exam, negative nerve and spinal cord tension-compression signs, and normal gait. Assessment is congenital spondylolysis lumbosacral.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic Right L5-S1 Medial Branch Block Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment for Workers Compensation, Low Back, and Criteria for the use of Diagnostic Blocks for Facet Mediated Pain

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Facet Injections; Facet Joint Pain, Signs & Symptoms

Decision rationale: The CA MTUS/ACOEM guidelines state, "Invasive Techniques (e.g., Local Injections and Facet-Joint Injections of Cortisone and Lidocaine) are of questionable merit." According to the Official Disability Guidelines, Lumbar Facet Joint Medial Branch Blocks as therapeutic injections, are not recommended, and may only be considered as a diagnostic tool. There is minimal evidence for use as treatment. The medical records do not document clinical findings that support the existence of facet-mediated pain. The request does not meet the guideline criteria; the medical necessity of the request is not established. The request is not medically necessary.

Continued Physical Therapy to the Lumbar Spine x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 58-59.

Decision rationale: The CA MTUS guidelines state patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Physical Medicine Guidelines - Allow for fading of treatment frequency (from up to three visits per week to one or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. The patient is several months post-date of injury. She reports PT only helped a little with her walking. She had been taken off work. There lacks evidence that physical therapy provided clinically significant objective functional improvement. Therefore, additional PT is not supported by the guidelines. The request is not medically necessary. The request is not medically necessary.