

Case Number:	CM14-0112603		
Date Assigned:	08/04/2014	Date of Injury:	07/30/2012
Decision Date:	09/23/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/18/2014

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 Physical Medicine and Rehabilitation 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 48-year-old female who reported an injury on 07/12/2012 due to being involved in an altercation with an inmate. The injured worker had a history of lower back pain and hip pain. The diagnosis included lower back pain with complaints of radiculopathy, left sacroiliac joint pain and strain, and arthritis. The MRI dated 04/14/2014 of the lumbar spine revealed disc bulge at the L3-4, grade 1 anterolisthesis with an annular disc tear and disc protrusion at the L4-5, and a disc bulge at the L5-S1. The past treatments included x-ray, medication, facet injections, and physical therapy. The past surgeries included a status post right total hip replacement dated 03/2013, and status post arm fracture. The objective findings dated 08/12/2014 of the lumbar spine revealed tenderness to the paraspinal muscles with negative straight leg raise, flexion 90 degrees, extension 10 degrees, and bilateral bending 10 degrees. Medications included Celebrex, Tirosint, tramadol HCL, folic acid, Remicade, and ibuprofen. No VAS was provided. The treatment plan included facet injections, and prescriptions for Flector patch and Ativan 1 mg. The Request for Authorization dated 08/04/2014 was submitted with the documentation. The rationale for the facet injections was for relieving pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L4-L5 Facet Joint Injection QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines-Low Back-Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines-Diagnostic Blocks.

Decision rationale: The request for Right L4-L5 Facet Joint Injection QTY: 1.00 is not medically necessary. The ACOEM Guidelines indicate that a facet neurotomy (Rhizotomy) should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As ACOEM does not address specific criteria for medial branch diagnostic blocks, secondary guidelines were sought. The Official Disability Guidelines indicate the criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings although pain may radiate below the knee, and a normal straight leg raise exam. There should be documentation of failure of conservative treatment including home exercise, physical therapy, and NSAIDS prior to the procedure for at least 4 to 6 weeks and no more than 2 facet joint levels should be injected in 1 session. Additionally, one set of diagnostic medial branch blocks is required with a response of 70%, and it is limited to no more than 2 levels bilaterally and they recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). The clinical note did not indicate conservative care had failed. The documentation indicated that the injured worker had received physical therapy; however, the physical therapy documentation was not provided. No functional measurements or deficits were provided in the documentation related to the medication. The clinical indicated that the injured worker received relief from prior facet injections; however, no degree was provided. As such, the request for Right L4-L5 Facet Joint Injection QTY: 1.00 is not medically necessary.

Left L4-L5 Facet Joint Injection QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines-Low Back-Lumbar & Thoracic (Acute & Chronic).

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

Decision rationale: The ACOEM Guidelines indicate that a facet neurotomy (Rhizotomy) should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As ACOEM does not address specific criteria for medial branch diagnostic blocks, secondary guidelines were sought. The Official Disability Guidelines indicate the criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings although pain

may radiate below the knee, and a normal straight leg raise exam. There should be documentation of failure of conservative treatment including home exercise, physical therapy, and NSAIDS prior to the procedure for at least 4 to 6 weeks and no more than 2 facet joint levels should be injected in 1 session. Additionally, one set of diagnostic medial branch blocks is required with a response of 70%, and it is limited to no more than 2 levels bilaterally and they recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). The clinical note did not indicate conservative care had failed. The documentation indicated that the injured worker had received physical therapy; however, the physical therapy documentation was not provided. No functional measurements or deficits were provided in the documentation related to the medication. The clinical indicated that the injured worker received relief from prior facet injections; however, no degree was provided. As such, the request for Left L4-L5 Facet Joint Injection QTY: 1.00 is not medically necessary.

Right L5-S1 Facet Joint Injection QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines-Low Back-Lumbar & Thoracic (Acute & Chronic).

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

Decision rationale: The ACOEM Guidelines indicate that a facet neurotomy (Rhizotomy) should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As ACOEM does not address specific criteria for medial branch diagnostic blocks, secondary guidelines were sought. The Official Disability Guidelines indicate the criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings although pain may radiate below the knee, and a normal straight leg raise exam. There should be documentation of failure of conservative treatment including home exercise, physical therapy, and NSAIDS prior to the procedure for at least 4 to 6 weeks and no more than 2 facet joint levels should be injected in 1 session. Additionally, one set of diagnostic medial branch blocks is required with a response of 70%, and it is limited to no more than 2 levels bilaterally and they recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). The clinical note did not indicate conservative care had failed. The documentation indicated that the injured worker had received physical therapy; however, the physical therapy documentation was not provided. No functional measurements or deficits were provided in the documentation related to the medication. The clinical indicated that the injured worker received relief from prior facet injections; however, no degree was provided. As such, the request for right L5-S1 Facet Joint Injection QTY: 1.00 is not medically necessary.

Left L5-S1 Facet Joint Injection QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines- Low Back-Lumbar & Thoracic (Acute & Chronic).

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

Decision rationale: The California ACOEM Guidelines indicate that a facet neurotomy (Rhizotomy) should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As ACOEM does not address specific criteria for medial branch diagnostic blocks, secondary guidelines were sought. The Official Disability Guidelines indicate the criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings although pain may radiate below the knee, and a normal straight leg raise exam. There should be documentation of failure of conservative treatment including home exercise, physical therapy, and NSAIDS prior to the procedure for at least 4 to 6 weeks and no more than 2 facet joint levels should be injected in 1 session. Additionally, one set of diagnostic medial branch blocks is required with a response of 70%, and it is limited to no more than 2 levels bilaterally and they recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). The clinical note did not indicate conservative care had failed. The documentation indicated that the injured worker had received physical therapy; however, the physical therapy documentation was not provided. No functional measurements or deficits were provided in the documentation related to the medication. The clinical indicated that the injured worker received relief from prior facet injections; however, no degree was provided. As such, the request for Left L5-S1 Facet Joint Injection QTY: 1.00 is not medically necessary.