

<b>Case Number:</b>	CM14-0044010		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	11/08/2001
<b>Decision Date:</b>	07/17/2014	<b>UR Denial Date:</b>	02/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/07/2014

### 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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 40-year-old man who sustained a work related injury on November 8, 2001. Subsequently, he developed a chronic low back pain that has been previously treated with physical therapy, chiropractic care, and epidural steroid injection. According to a medical evaluation report dated on January 27, 2014, his physical examination revealed full lumbar range of motion, no tenderness, full motor strength and intact sensation in the bilateral upper and lower extremities, in addition to an unremarkable orthopedic examination. The patient's lumbar MRI performed on May 2, 2011 showed mild disc desiccation, mild annular tear and mild bulging at L4-5 and L5-S1 in addition to mild facet disease at L4-5 bilaterally. Lumbar CT scan performed on December 10, 2013 showed minimal disc space narrowing at L4-5 and L5-S1 with mild disc bulging but no significant stenosis. Lumbar X-rays dated on January 27, 2014 showed very mild disc space narrowing at L4-5 and L5-S1. The patient's current medication include Norco, Soma, Avinza, and docusta sodium. The provider requested authorization for a second opinion consultation for low back pain, lumbar facet injections, and X-ray of the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 SECOND OPINION CONSULTATION FOR LOW BACK PAIN: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 171, Chronic Pain Treatment Guidelines Chronic pain programs, early intervention Page(s): 32-33.

**Decision rationale:** According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a pain management evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. In the chronic pain programs, early intervention section of MTUS guidelines stated: Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach: (a) The patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis. (c) There is a previous medical history of delayed recovery. (d) The patient is not a candidate where surgery or other treatments would clearly be warranted. (e) Inadequate employer support. (f) Loss of employment for greater than 4 weeks. The most discernable indication of at risk status is lost time from work of 4 to 6 weeks. (Mayer 2003). As per the evaluation dated on January 27, 2014, there is no clear evidence of any significant findings that would warrant a surgery evaluation. There are no red flags, focal neurological findings and progressive neurological condition that point toward a surgery evaluation or surgery intervention in this patient. Therefore, the request for Second opinion low back pain is not medically necessary.

**(1) REFERRAL FOR LUMBAR FACET INJECTIONS AT L4-5 AND L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 309.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** According to MTUS guidelines, Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain. According to ODG guidelines regarding facet injections, Under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in concert with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti, 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the

overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial. Furthermore and according to ODG guidelines, Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: 1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time. 5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. The ODG guidelines did not support facet injection for lumbar pain in this clinical context. There is no documentation of facet mediated pain. In addition, there is no clear evidence or documentation that lumbar facets are main pain generator. Therefore, the Referral For Lumbar Facet Injections At L4-5 And L5-S1 is not medically necessary.

**(1) X-RAY OF THE LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

**Decision rationale:** According to Low Back Complaints ACOEM guidelines, x ray of the lumbar spine is indicated in case of disc protrusion, post laminectomy syndrome, spinal stenosis and equina syndrome. There is no red flags pointing toward one of the above diagnosis or a serious spine pathology. The patient developed a back injury without any focal neurological examination. Therefore the request of X ray of the lumbar spine is not medically necessary.