

Case Number:	CM14-0089431		
Date Assigned:	07/23/2014	Date of Injury:	01/26/2012
Decision Date:	08/27/2014	UR Denial Date:	06/03/2014
Priority:	Standard	Application Received:	06/13/2014

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 Interventional Spine 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 with a date of injury of 01/26/2012. The listed diagnoses per [REDACTED] are: 1. Post-laminectomy syndrome. 2. Facet joint syndrome. 3. Nerve root compression, lumbar. 4. Myalgia, myositis. 5. Neuralgia, neurosis, and radiculitis. According to progress report 05/12/2014 by [REDACTED], the patient presents with persistent low back pain. Patient states the pain is constant, severe, with restricted movement and instability. She further describes it as a numbness sensation with pain localized in the left sacroiliac and lumbar area. Examination of the lumbar spine revealed tenderness on the left at L2, L3, L4, and L5. The left SI joint and iliolumbar showed moderate tenderness. Straight leg raise was negative bilaterally. MRI of the lumbar spine from 03/01/2013 revealed post cervical changes at L3-L4 consistent with posterior laminectomy. There was inflammation of the paraspinal musculature from L1 to L5 levels. L4-L5 revealed broad-based disk bulges associated with posterior facet arthrosis. Treater states the patient is status post L4 laminectomy with resolution of the pseudomeningocele since 2013. He is requesting a diagnostic medial branch block at L4 to S1, left and right, to rule out facet joint syndrome. The treater is also requesting 1 follow-up visit per month for 45 minutes each visit. Utilization review denied the request on 06/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Follow-up visit per month (45 minutes each visit): 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): 303.

Decision rationale: This patient presents with persistent low back pain. The treater is requesting 1 followup visit per month for 45 minutes each visit. Utilization review denied the request stating, "there is no medical need for the patient to undergo serial evaluations of such complexity." ACOEM, ch 12, Low Back, Pg 303, has the following regarding Follow-up Visits: "Patients with potentially work-related low back complaints should have follow up every three to five days by a midlevel practitioner or physical therapist who can counsel the patient about avoiding static positions, medication use, activity modification, and other concerns." This, however, applies to acute/subacute phase of injury. This patient suffers from chronic pain. At times, the patient very well may require 45 minutes for a follow-up but unlikely on every visitation. MTUS page 8 does require that the treating physician provide monitoring and make appropriate recommendations. However, the current request does not explain why the patient requires such a high level of care every visit and the request is open-ended. The treater must provide documentation regarding the complexity of the case and treatments should be time-limited. Recommendation is for denial.

1 Diagnostic Medial Branch Block at L4, L5, and S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines on Lumbar Facet joint signs & symptoms: Recommend diagnostic criteria below. Diagnostic blocks are required as there are no findings on history, physical or imaging studies that consistently aid in making this diagnosis. Controlled comparative blocks have been suggested due to the high false-positive rates (17% to 47% in the lumbar spine), but the use of this technique has not been shown to be cost-effective or to prevent a false-positive response to a facet neurotomy. (Bogduk, 2005) (Cohen 2007) (Bogduk, 2000) (Cohen2, 2007) (Manchukonda 2007) (Dreyfuss 2000) (Manchikanti 2003) The most commonly involved lumbar joints are L4-5 and L5-S1. (Dreyfus, 2003) In the lumbar region, the majority of patients have involvement in no more than two levels. (Manchikanti, 2004) Mechanism of injury: The cause of this condition is largely unknown, but suggested etiologies have included microtrauma, degenerative changes, and inflammation of the synovial capsule. The overwhelming majority of cases are thought to be the result of repetitive strain and/or low-grade trauma accumulated over the course of a lifetime. Less frequently, acute trauma is thought to be the mechanism, resulting in tearing of the joint capsule or stretching beyond physiologic limits. Osteoarthritis of the facet joints is commonly found in association with degenerative joint disease. (Cohen 2007) Symptoms: There is no reliable pain referral pattern, but it is suggested that pain from upper facet joints tends to extend to the flank, hip and upper lateral thighs, while the lower joint mediated pain tends to penetrate

deeper into the thigh (generally lateral and posterior). Infrequently, pain may radiate into the lateral leg or even more rarely into the foot. In the presence of osteophytes, synovial cysts or facet hypertrophy, radiculopathy may also be present. (Cohen 2007) In 1998, Revel et al. suggested that the presence of the following were helpful in identifying patients with this condition: (1) age > 65; (2) pain relieved when supine; (3) no increase in pain with coughing, hyperextension, forward flexion, rising from flexion or extension/rotation. (Revel, 1998) Recent research has corroborated that pain on extension and/or rotation (facet loading) is a predictor of poor results from neurotomy. (Cohen2, 2007) The condition has been described as both acute and chronic. (Resnick, 2005) Radiographic findings: There is no support in the literature for the routine use of imaging studies to diagnose lumbar facet mediated pain. Studies have been conflicting in regards to CT and/or MRI evidence of lumbar facet disease and response to diagnostic blocks or neurotomy. (Cohen 2007) Degenerative changes in facets identified by CT do not correlate with pain and are part of the natural degenerative process. (Kalichman, 2008) See also Facet joint diagnostic blocks (injections); & Segmental rigidity (diagnosis). Suggested indicators of pain related to facet joint pathology (acknowledging the contradictory findings in current research): (1) Tenderness to palpation in the paravertebral areas (over the facet region); (2) A normal sensory examination; (3) Absence of radicular findings, although pain may radiate below the knee; (4) Normal straight leg raising exam. Indicators 2-4 may be present if there is evidence of hypertrophy encroaching on the neural foramen. For Facet joint diagnostic blocks for both facet joint and Dorsal Median Branches, ODG ODG has the following: 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). Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates.

Decision rationale: This patient presents with persistent low back pain. The treater is requesting a diagnostic medial branch block, L4 to S1, both left and right, to rule out facet joint syndrome. ACOEM Guidelines do not support facet injections for treatments, but does discuss dorsal median branch blocks as well as radio-frequency ablations on page 300 and 301. ODG guidelines also support facet diagnostic evaluations for patient's presenting with paravertebral tenderness with non-radicular symptoms. In this case, the patient has lumbar neuralgia, neurosis, and radiculitis. MTUS does not recommend facet injections for patients with radicular symptoms. More importantly, as medical records document, this patient is status post L4 laminectomy and the patient did present with radiculopathy. Recommendation is for denial.