

<b>Case Number:</b>	CM14-0095989		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	11/16/2012
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	06/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/24/2014

### 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 Neuromuscular Medicine and is licensed to practice in Maryland. 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 57 year old male with a work injury dated 11/16/12. The diagnoses include multilevel herniated nucleus pulposus of the cervical spine and lumbar spine and cervical and lumbar radiculopathy. Under consideration is a request for a rhizotomy at L5-S1 and an interlaminar epidural steroid injection at C5-6. There is a primary treating physician (PR-2) document dated 5/12/14 documenting the patient reports his overall condition has become worse since his last visit. The patient has now undergone 25 sessions of acupuncture therapy to the lower back, which provided temporary pain relief. The patient last worked in 02/16/2013. The patient currently complains of aching and burning neck pain with radiation of aching pain and burning pain to the bilateral shoulders and to the mid back. The patient currently rates his neck pain at a 7/10 on the pain scale. The patient reports prolonged sitting exacerbates his pain which makes it difficult for him to sit in a car for long periods of time. The patient also complains of burning, aching and cramping back pain with radiation of aching pain, pins, needles, and burning pain to the right lower extremities down to thigh. The patient currently rates his back pain at 8/10 on the pain scale. With regards to medications, the patient reports he takes Norco 10/325mg three times a day and Gabapentin 600mg two times a day. On exam the gait is antalgic, there is tenderness to palpation over the cervical and lumbar spine, diminished range of motion in the cervical and lumbar spine and decreased sensation left C6-C7 dermatome. Lower extremity sensation is intact bilaterally. Motor exam 4+/5 left deltoids, biceps, wrist flexors/extensors, 4+/5 bilateral Quadriceps, hamstrings, tibialis anterior, extensor hallucis longus (EHL), plantar flexion/extension. Positive straight leg test on the right side. The treatment plan states that due to the patient's positive results from the medial branch block (MBB) at bilateral L5-S1, a rhizotomy at L5-S1 is requested. There is a 4/23/14 primary treating physician document that states that the

patient recently had a bilateral MBB at L5-S1 on 3/25/2014, which provided at least 50% relief in his symptoms for around 2 hours. The patient continues to describe aching, cramping in his neck and bilateral shoulder area, which he rates 7-8/10 on the pain scale. He also describes stabbing, aching, and cramping in his upper, mid and low back. He notes this pain also radiates across his low back and rates it 7-8/10. On exam there is decreased sensation in the right C6 and C7 dermatomes. Lower extremity sensation is intact bilaterally. Motor exam 4+/5 right deltoids, biceps, internal and external rotators, wrist extensors and flexors. Motor strength is 4+/5 for right and 5-/5 on the left of the quadriceps, hamstrings, tibialis anterior, EHL, inversion, plantar flexion, and eversion. The treatment plan is for interlaminar epidural steroid injection C5-C6 as well. This is an injection that is both therapeutic and diagnostic as well as a bilateral L5-S1 rhizotomy. There is an MRI of the cervical spine, report only dated 04/15/2013 that reveals degenerative disc disease and facet arthropathy with retrolisthesis C5-C6, canal stenosis includes C3-C4 and C4-C5 mild, C5-C6 mild-to-moderate, and neural foraminal narrowing includes C4-C5 mild left and C5-C6 as severe bilaterally. This is an MRI of the lumbar spine dated 1/06/2014 which reveals dextroscoliosis with degenerative disc disease and facet arthropathy and retrolisthesis L2-3, L3-4, L4-5 and L5-S1, canal stenosis includes L3-4 moderate to severe, L4-5 mild to moderate, neural foraminal narrowing includes L1-2 caudal right, L2-3 mild to moderate left, moderate to severe right, L3-4 moderate bilateral, L4-5 moderate bilateral, L5-S1 moderate to severe left.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Rhizotomy at L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines: Facet Joint Radiofrequency Neurotomy.

**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) Low back- Facet joint diagnostic blocks (injections); Facet joint medial branch blocks (therapeutic injections).

**Decision rationale:** The MTUS ACOEM guidelines state that lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The ODG states that facet joint blocks should be used as a diagnostic tool. The diagnostic medial branch blocks should have a response of 70%. The pain response should last at least 2 hours for Lidocaine. The documentation submitted reveals that a 4/23/14 primary treating physician document states that the patient had a bilateral MBB at L5-S1 on 3/25/2014, which provided at least 50% relief in his symptoms for around 2 hours. The patient does not meet the criteria for rhizotomy per the guidelines and therefore a L5-S1 rhizotomy is not medically necessary.

#### **Interlaminar Epidural Steroid Injection at C5-C6: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back Chapter (ESI).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 45.

**Decision rationale:** The guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The documentation reveals cervical imaging findings of severe bilateral neural foraminal narrowing at C5-6. The physical exam reveals motor findings in the C5 and C6 myotomes and sensory abnormalities in the C6 dermatomes bilaterally. Therefore the physical exam and imaging studies reveal that it is medically appropriate to attempt an interlaminar epidural steroid injection at C5-C6. The interlaminar epidural steroid injection at C5-C6 is medically necessary.