

<b>Case Number:</b>	CM15-0166626		
<b>Date Assigned:</b>	09/04/2015	<b>Date of Injury:</b>	11/08/2012
<b>Decision Date:</b>	10/08/2015	<b>UR Denial Date:</b>	08/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, California

Certification(s)/Specialty: Family Practice

### 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 43-year-old male who sustained a work related injury November 8, 2012. Past history included cervical fusion 2013. On June 2, 2015, he underwent a right L4-5 and right L5-S1 medial branch nerve block with a diagnosis of facet arthropathy. According to a physician's office visit notes, dated August 5, 2015, the injured worker presented with continued neck and lower back pain. He reports certain positions cause's flare-ups and he has to reposition himself due to the pain and cramping. Symptoms in the neck begin in the occipital area and then across the trapezius muscles consistently, with occasional radiation down the left arm. Physical examination of the lumbar spine revealed no radiculopathy. Physical examination of the cervical spine revealed limited range of motion and positive facet loading test and negative Spurling test. Assessments are documented as brachial neuritis or radiculitis, not otherwise specified; thoracic-lumbar radiculitis-neuritis; degenerative joint disease, arthritis, cervical spine; lumbar spondylosis without myelopathy. Treatment plan included heat-ice to affected area, rehab exercises and stretches, and at issue, a request for authorization for a lumbar spine rhizotomy, cervical spine selective left C7 nerve root block, and patient controlled inversion table (purchase) for lumbar spine. The medication list includes Norco, Soma, Temazepam, Morphine and Mobic. Per the note dated 7/13/15, the patient had complaints of pain in neck and back. Physical examination of the lumbar spine revealed limited range of motion and positive SLR. The patient has had history of failed back surgery and cervical fusion in 2013. Per the note dated 7/15/15, the patient had complaints of pain in neck and back. Physical examination of the lumbar spine revealed tenderness on palpation, negative SLR, positive Faber and facet loading test. Patient had received cervical and lumbar ESI for this injury. The patient had used a TENS unit for this injury. The patient had received an unspecified number of PT visits for this injury.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Lumbar spine Rhizotomy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back - Facet joint pain, signs & symptoms - Facet joint radiofrequency neurotomy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 09/22/15) Facet joint intra-articular injections (therapeutic blocks), Facet joint radiofrequency neurotomy.

**Decision rationale:** Request: Lumbar spine Rhizotomy. CA MTUS and ACOEM Guidelines do not address this request. Therefore ODG used. As per cited guideline for facet joint radiofrequency neurotomy "Under study Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis (only 3 RCTs with one suggesting pain benefit without functional gains, potential benefit if used to reduce narcotics). Studies have not demonstrated improved function." "Criteria for use of facet joint radiofrequency neurotomy: (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections). 2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period. 3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function. 4) No more than two joint levels are to be performed at one time. 5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks. 6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy." "Factors associated with failed treatment: These include increased pain with hyperextension and axial rotation (facet loading), longer duration of pain and disability, significant opioid dependence, and history of back surgery." As per the records, provided the patient has had history of failed back surgery. As per cited guideline, there should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy, which was not specified in the records provided. Patient has received an unspecified number of the PT visits conservative treatment this injury until date. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The medical necessity of the request for Lumbar spine Rhizotomy is not fully established in this patient.

### **Cervical spine Selective Left C7 Nerve Root Block: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and upper back - Epidural steroid injections (ESI).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** Request: Cervical spine Selective Left C7 Nerve Root Block. The MTUS Chronic Pain Guidelines regarding Epidural Steroid Injections state, "The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." Per the cited guideline, criteria for ESI are "1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)." Radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing was not specified in the records provided. Consistent objective evidence of upper extremity radiculopathy was not specified in the records provided. Lack of response to conservative treatment including exercises, physical methods, NSAIDs and muscle relaxants was not specified in the records provided. The patient had received an unspecified number of the PT visits for this injury. Any conservative therapy notes were not specified in the records provided. A response to recent rehab efforts including physical therapy or continued home exercise program were not specified in the records provided. As stated above, epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The records provided did not specify a plan to continue active treatment programs following the cervical ESI. As stated above, ESI alone offers no significant long-term functional benefit. The patient had received ESI in cervical region for this injury. Per the cited guidelines, "repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks." There was no evidence of objective documented pain and functional improvement, including at least 50% pain relief for six to eight weeks after the previous cervical ESIs. Evidence of associated reduction of medication use, was not specified in the records provided. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. With this, it is deemed that the medical necessity of request for cervical spine Selective Left C7 Nerve Root Block is not fully established for this patient.

### **Patient controlled Inversion Table (purchase) for lumbar spine: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back chapter - Home inversion table, Official Disability Guidelines (ODG), Low back chapter - Traction.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 09/22/15), Home inversion table, Traction.

**Decision rationale:** Request: Patient controlled Inversion Table (purchase) for lumbar spine. As per cited guideline, "Traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended." According the cited guidelines, "Not recommended using powered traction devices, but home-based patient controlled gravity traction may be a noninvasive conservative option, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration. As a sole treatment, traction has not been proved effective for lasting relief in the treatment of low back pain." Therefore mechanical traction is has not been proved effective for lasting relief in the treatment of low back pain and is not recommended by the cited guideline. Detailed response to previous conservative therapy was not specified in the records provided. Prior conservative therapy visit notes were not specified in the records provided. The response of the symptoms to a period of rest, oral pharmacotherapy is not specified in the records provided. The records provided did not specify any recent physical therapy with active PT modalities or a plan to use the traction unit as an adjunct to a program of evidence-based functional restoration. Any evidence of diminished effectiveness of medications or intolerance to medications (that would preclude the use of oral medications) was not specified in the records provided. The medical necessity of the request for Patient controlled Inversion Table (purchase) for lumbar spine is not fully established in this patient.