

Case Number:	CM15-0025268		
Date Assigned:	02/17/2015	Date of Injury:	01/17/2013
Decision Date:	04/09/2015	UR Denial Date:	01/21/2015
Priority:	Standard	Application Received:	02/10/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 45-year-old male, who sustained an industrial injury on January 17, 2013. The injured worker had reported a neck and back injury. The diagnoses have included cervical and lumbar facet arthropathy. Treatment to date has included pain medication, physical therapy, x-rays of the lumbar spine, MRI of the lumbar and cervical spine, a home exercise program and status post cervical fusion. The x-rays of the lumbar spine revealed a mild compression fracture at lumbar three and lumbar four. Current documentation dated December 16, 2014 notes that the injured worker continued to complain of neck stiffness and low back pain and stiffness. Physical examination of the low back revealed a tremendous amount of spasms in the right lower back muscles. Range of motion was limited throughout the lumbar and cervical spine. On January 21, 2015 Utilization Review non-certified a request for a soft lumbar corset, lumbar facet blocks at lumbar three-sacral one with fluoroscopy and cervical facet blocks at cervical three-four, cervical four-five and cervical five-six with fluoroscopy and modified a request for physical therapy three times a week for two weeks for the lumbar and cervical spine. The MTUS, ACOEM Guidelines and the Official Disability Guidelines, were cited. On February 10, 2015, the injured worker submitted an application for IMR for review of a soft lumbar corset, lumbar facet blocks at lumbar three-sacral one with fluoroscopy and cervical facet blocks at cervical three-four, cervical four-five and cervical five-six with fluoroscopy and physical therapy three times a week for two weeks for the lumbar and cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3x a week for two weeks for the lumbar and cervical spine: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: The patient presents with unrated severe neck and lower back stiffness and pain. Patient also complains of weakness, lack of endurance, and low energy. The patient's date of injury is 01/17/13. Patient is status post right ankle removal of deep hardware on 11/12/14, status post unspecified undated cervical fusion C1-C3. The request is for physical therapy 3x a week for two weeks for the lumbar and cervical spine. The RFA is dated 01/13/15. Physical examination dated 11/18/14 reveals tenderness to palpation of the lumbar spine and cervical spine, reduced range of motion of L/C spine in all planes, and notes significant spasms to the lumbar paraspinal muscles. The patient is currently prescribed Flector patches. Diagnostic imaging included MRI of the cervical and lumbar spine dated 07/11/14, significant cervical findings include: "there is prior multilevel posterior spinal fusion spanning C1 through C3." Significant lumbar findings include: "L4-5 there is a 2.5 to 3.5mm broad based posterior disc bulge most pronounced posterolaterally" L5-S1: There is a 3 to 3.5mm left posterolateral disc protrusion at this level contributing to mild to moderate left L5-S1 lateral recess stenosis. Patient is not currently working. MTUS pages 98, 99 have the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency -from up to 3 visits per week to 1 or less, plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. "In regards to the request for 6 physical therapy sessions for the management of this patient's chronic pain, the request appears reasonable. The documentation provided does not indicate that this patient has undergone any physical therapy directed at his neck and lower back pain. MTUS supports up to 10 visits for complaints of this nature, the treater is requesting 6. Therefore, the request IS medically necessary.

Soft lumbar corset: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter, Lumbar supports.

Decision rationale: The patient presents with unrated severe neck and lower back stiffness and pain. Patient also complains of weakness, lack of endurance, and low energy. The patient's date of injury is 01/17/13. Patient is status post right ankle removal of deep hardware on 11/12/14,

status post unspecified undated cervical fusion C1-C3. The request is for soft lumbar corset. The RFA is dated 01/13/15. Physical examination dated 11/18/14 reveals tenderness to palpation of the lumbar spine and cervical spine, reduced range of motion of L/C spine in all planes, and notes significant spasms to the lumbar paraspinal muscles. The patient is currently prescribed Flector patches. Diagnostic imaging included MRI of the cervical and lumbar spine dated 07/11/14, significant cervical findings include: "there is prior multilevel posterior spinal fusion spanning C1 through C3." Significant lumbar findings include: "L4-5 there is a 2.5 to 3.5mm broad based posterior disc bulge most pronounced posterolaterally" L5-S1: There is a 3 to 3.5mm left posterolateral disc protrusion at this level contributing to mild to moderate left L5-S1 lateral recess stenosis. Patient is not currently working. The ACOEM Guidelines page 301 on lumbar bracing states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines under the Low Back chapter on lumbar supports states, "Not recommended for prevention; however, recommended as an option for compression fracture and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain, very low quality evidence, but may be a conservative option." In regards to the request for what appears to be a soft lumbar brace, the request is not supported by guidelines for nonspecific lumbar pain. Progress reports provided do not indicate that this patient has been issued any DME bracing for the lumbar spine to date. While ODG guidelines indicate that such bracing is a conservative option for nonspecific low back pain there is very low grade evidence for this. The request IS NOT medically necessary.

Lumbar facet blocks, L3-S1 with fluoroscopy: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back Chapter, under Facet Joint Medial Branch blocks - Therapeutic.

Decision rationale: The patient presents with unrated severe neck and lower back stiffness and pain. Patient also complains of weakness, lack of endurance, and low energy. The patient's date of injury is 01/17/13. Patient is status post right ankle removal of deep hardware on 11/12/14, status post unspecified undated cervical fusion C1-C3. The request is for lumbar facet blocks, L3-S1 with fluoroscopy. The RFA is dated 01/13/15. Physical examination dated 11/18/14 reveals tenderness to palpation of the lumbar spine and cervical spine, reduced range of motion of L/C spine in all planes, and notes significant spasms to the lumbar paraspinal muscles. The patient is currently prescribed Flector patches. Diagnostic imaging included MRI of the cervical and lumbar spine dated 07/11/14, significant cervical findings include: "there is prior multilevel posterior spinal fusion spanning C1 through C3." Significant lumbar findings include: "L4-5 there is a 2.5 to 3.5mm broad based posterior disc bulge most pronounced posterolaterally" L5-S1: There is a 3 to 3.5mm left posterolateral disc protrusion at this level contributing to mild to moderate left L5-S1 lateral recess stenosis. Patient is not currently working. ODG Low Back Chapter, under Facet Joint Medial Branch blocks - Therapeutic- states: "Not recommended except as a diagnostic tool. Minimal evidence for treatment." ODG Low Back Chapter, under Facet Joint Diagnostic Blocks states: "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 that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block. Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself."In regards to the request for a diagnostic lumbar facet block, the request appears reasonable. Progress notes provided do not indicate that this patient has undergone any lumbar facet blocks to date. There is no evidence that this patient has undergone any fusions at these levels to date, either. While there is no discussion of anticipated neurotomy directed at this level, given this patient's persistent lower back pain without radiculopathic symptoms, a diagnostic block is an appropriate measure. Therefore, the request IS medically necessary.

Cervical facet blocks C3-4, C4-5, C5-6 with fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper Back Chapter, under Facet joint diagnostic blocks.

Decision rationale: The patient presents with unrated severe neck and lower back stiffness and pain. Patient also complains of weakness, lack of endurance, and low energy. The patient's date of injury is 01/17/13. Patient is status post right ankle removal of deep hardware on 11/12/14, status post unspecified undated cervical fusion C1-C3. The request is for cervical facet blocks C3-4, C4-5, C5-6 with fluoroscopy. The RFA is dated 01/13/15. Physical examination dated 11/18/14 reveals tenderness to palpation of the lumbar spine and cervical spine, reduced range of motion of L/C spine in all planes, and notes significant spasms to the lumbar paraspinal muscles. The patient is currently prescribed Flector patches. Diagnostic imaging included MRI of the cervical and lumbar spine dated 07/11/14, significant cervical findings include: "there is prior multilevel posterior spinal fusion spanning C1 through C3." Significant lumbar findings include: "L4-5 there is a 2.5 to 3.5mm broad based posterior disc bulge most pronounced posterolaterally" L5-S1: There is a 3 to 3.5mm left posterolateral disc protrusion at this level contributing to mild to moderate left L5-S1 lateral recess stenosis. Patient is not currently working. ODG-TWC, Neck and Upper Back Chapter, under Facet joint diagnostic blocks states: "Recommended prior to facet neurotomy (a procedure that is considered 'under study'). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block. Criteria for the use of diagnostic blocks for facet nerve pain: Clinical presentation should be

consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine. 2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment -including home exercise, PT and NSAIDs- prior to the procedure for at least 4-6 weeks. 4. No more than 2 joint levels are injected in one session. 8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. "For facet joint pain signs and symptoms, the ODG guidelines state that physical examination findings are generally described as: "1. Axial pain, either with no radiation or severely past the shoulders; 2. Tenderness to palpation in the paravertebral areas, over the facet region; 3. Decreased range of motion, particularly with extension and rotation; and 4. Absence of radicular and/or neurologic findings." In regards to the request for a diagnostic cervical facet block, the requested treatment does not meet guideline criteria. While there is no evidence of cervical facet blocks being performed to date, MRI of the cervical spine dated 07/11/14 indicates that this patient has undergone a C1 through C3 posterior fusion at some point in the past. A discussion of this procedure or operative report was not provided. Furthermore, ODG does not support more than two levels of facet joint injections/evaluations. The current request is for 3 level injections. The request IS NOT medically necessary.