

<b>Case Number:</b>	CM15-0047271		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	03/26/2008
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 56-year-old female, who sustained an industrial injury on March 26, 2008. The injured worker was diagnosed as having status post shoulder arthroscopy decompression, distal clavicle resection and manipulation under anesthesia on November 6, 2012, diffuse adhesions and fibrosis per diagnostic ultrasound study dated September 25, 2014, status post left knee arthroscopy dated march 23, 2011 with residual patellofemoral arthralgia, patellofemoral and medial compartment osteoarthritis, distal patellar tendon partial tear and avulsion fracture, per diagnostic ultrasound on November 5, 2014, lumbar musculoligamentous sprain/strain with left lower radiculitis and facet changes at L4-5 and three millimeter disc bulge and stenosis at L3 through L5 per Magnetic resonance imaging scan September 2008 and bilateral sacroiliac sprain, left hand flexor tenosynovitis in the second, third and fourth digits, cervical/trapezial musculoligamentous sprain/strain with left upper extremity radiculitis and right wrist sprain/strain secondary to cane use. Treatment to date has included lumbar spine Rhizotomy and opioids. Currently, the injured worker complains of lumbar spine pain with radiation to the buttocks and left knee pain with popping, clicking and giving away. In a progress note dated February 6, 2015, the treating provider reports examination of the lumbar spine revealed tenderness to palpation with spasm over the paraspinal musculature, straight leg raising elicits localized pain, decreased range of motion, the left knee has diffuse swelling on the medial joint line and crepitus.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Repeat lumbar spine rhizotomy (unspecified level and side) Qty: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Facet joint intra-articular injections (therapeutic blocks) ([http://worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm#Facetjointinjections](http://worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#Facetjointinjections)).

**Decision rationale:** According 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 facets 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 consort 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 two 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. According to MTUS guidelines, “there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. 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 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 request for Repeat lumbar spine rhizotomy is not medically necessary.

**Retrospective: Left knee patellar support (dispensed 02/06/15) Qty: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee brace. <http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines, Knee brace is < Recommended as indicated below. Recommend valgus knee braces for knee OA. Knee braces that produce a valgus moment about the knee markedly reduce the net knee adduction moment and unload the medial compartment of the knee, but could be impractical for many patients. There are no high quality studies that support or refute the benefits of knee braces for patellar instability, ACL tear, or MCL instability, but in some patients, a knee brace can increase confidence, which may indirectly help with the healing process. Criteria for the use of knee braces: Prefabricated knee braces may be appropriate in patients with one of the following conditions: 1. Knee instability; 2. Ligament insufficiency/deficiency; 3. Reconstructed ligament; 4. Articular defect repair; 5. Avascular necrosis; 6. Meniscal cartilage repair; 7. Painful failed total knee arthroplasty; 8. Painful high tibial osteotomy; 9. Painful unicompartmental osteoarthritis; 10. Tibial plateau fracture. Custom-fabricated knee braces may be appropriate for patients with the following conditions which may preclude the use of a prefabricated model: 1. Abnormal limb contour, such as: a. Valgus [knock-kneed] limb; b. Varus [bow-legged] limb; c. Tibial varum; d. Disproportionate thigh and calf (e.g., large thigh and small calf); e. Minimal muscle mass on which to suspend a brace. 2. Skin changes, such as: a. Excessive redundant soft skin; b. Thin skin with risk of breakdown (e.g., chronic steroid use). 3. Severe osteoarthritis (grade III or IV). 4. Maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain). 5. Severe instability as noted on physical examination of knee. There is no clear and recent documentation of knee instability or ligament damage avascular necrosis or any other indication for knee brace. Therefore, the request for Retrospective: Left knee patellar support (dispensed 02/06/15) Qty: 1.00 is not medically necessary.