

Case Number:	CM14-0161094		
Date Assigned:	10/06/2014	Date of Injury:	03/29/2006
Decision Date:	11/04/2014	UR Denial Date:	09/10/2014
Priority:	Standard	Application Received:	10/01/2014

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 Orthopedic Spine Surgeon and is licensed to practice in Texas. 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 injured worker is a 67-year-old male who reported an injury on 03/29/2006. The mechanism of injury was the injured worker unloaded a box that weighed approximately 300 pounds to 400 pounds and put it into the trailer. The injured worker was noted to have a sharp pain in his low back. The injured worker had an anterior posterior fusion at L2-S1. The prior treatments included physical therapy and chiropractic care. The injured worker underwent an MRI and an EMG. The injured worker's medications included Hyzaar, Vistaril, hydrochlorothiazide, Nexium, Soma, and nonsteroidal anti-inflammatories. The injured worker underwent an MRI of the lumbar spine without contrast on 04/24/2013 which revealed at the level of L1-2 there was a severe loss of disc height and signal intensity. There was a 6 mm to 7 mm left greater than right diffuse bulging of the annulus extending centrally and in particular within the left lateral recess and left neural foramen and far laterally. It was further stated this in combination with moderate facet hypertrophy resulted in moderate to severe canal stenosis in the left lateral recess impinging the left L2 nerve root and resulting in severe left foraminal stenosis with impingement of the left exiting L1 nerve root within the left neural foramen in combination with facet hypertrophy. At the level of L5-S1, there was a posterior fusion and anterior fusion with graft and anterior clips and pedicle screws and rods. There was no canal or lateral recess stenosis. There was some residual osteophyte extending into the right neural foramen which moderately narrowed the right neural foramen. There was left sided residual osteophyte that was mild to moderately narrowing the left neural foramen. The documentation indicated the injured worker had failed TENS unit, physical therapy, therapeutic exercises, pharmacological therapy, and other nonsurgical modalities. The injured worker underwent an MRI of the lumbar spine on 07/31/2014 which revealed at the level of L1-2 there was a 4 mm disc osteophyte complex with mild spinal canal narrowing. There was facet arthropathy causing moderate bilateral neural foraminal narrowing.

At L5-S1, there was moderate bilateral neural foraminal narrowing at L5-S1 with combination of disc osteophyte complex and facet arthropathy. The documentation of 08/11/2014 revealed the injured worker had a constant ache with some episodes of sharp stabbing sensations. Transdermal creams were noted to have assisted somewhat. The physical examination revealed the injured worker had lumbar facet tenderness at L1-2 and below the fusion at L5-S1. The injured worker has positive lumbar facet loading maneuvers and the straight leg raise was within normal limits bilaterally. The treatment plan included the injured worker had failed multiple conservative therapies including physical therapy, NSAIDs, TENS, and various medication trials with no benefit. The diagnosis included chronic pain syndrome, lower back pain, postlaminectomy syndrome of the lumbar region, Cymbalta, and Norco 10/325 mg. The treatment included a bilateral L1-2 and L5-S1 facet joint injection that was noted to be above and below the level of fusion. Additionally, the request was made for medications and a continuation for the injured worker to proceed with core muscle strengthening. There was a rationale and a Request for Authorization dated 08/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

(1) Lumbar Facet Joint Injections bilateral L1-L2 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Low Back Chapter, Facet joint diagnostic blocks

Decision rationale: The American College of Occupational and Environmental Medicine Guidelines indicate that a facet neurotomy (Rhizotomy) should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As American College of Occupational and Environmental Medicine does not address specific criteria for medial branch diagnostic blocks, secondary guidelines were sought. The Official Disability Guidelines indicate the criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings although pain may radiate below the knee, and a normal straight leg raise exam. There should be documentation of failure of conservative treatment including home exercise, physical therapy, and NSAIDS prior to the procedure for at least 4 to 6 weeks and no more than 2 facet joint levels should be injected in 1 session. Additionally, one set of diagnostic medial branch blocks is required with a response of 70%, and it is limited to no more than 2 levels bilaterally and they 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 facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. The clinical documentation submitted for review indicated the injured worker had a prior fusion at L5-S1, per MRI. There was documentation indicating the injured worker had failed conservative care. However, there was a lack of

documentation indicating whether the injured worker had a normal sensory examination. Given the above, the request for 1 lumbar facet joint injection bilateral L1-2 and L5-S1 is not medically necessary.