

<b>Case Number:</b>	CM15-0036293		
<b>Date Assigned:</b>	03/04/2015	<b>Date of Injury:</b>	10/12/2005
<b>Decision Date:</b>	06/15/2015	<b>UR Denial Date:</b>	02/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/26/2015

### 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 York  
 Certification(s)/Specialty: Internal 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 42-year-old male, who sustained an industrial injury on 10/12/05. He has reported low back pain related to lifting a heavy object. The injured worker reported that he has injured his lumbar spine 3-4 times previously. The diagnoses have included lumbar radiculopathy, L4-L5 and L5-S1 disc extrusion and status post laminectomy. Treatment to date has included physical therapy, chiropractic treatments, lumbar MRI, epidural injections, EMG/NCV studies and pain medications. As of the PR2 dated 2/9/15, the injured worker reports 60% pain relief from diagnostic lumbar epidural injections. The treating physician requested a lumbar epidural injection, a lumbar/cervical facet joint injection, a lumbar/cervical medial branch nerve block, a spinal cord stimulator trial, a spinal cord stimulator implant, a lumbar/cervical radiofrequency thermal coagulation (RFTC) and a lumbar cervical discogram with CT scan. On 2/21/15 Utilization Review non-certified a request for a lumbar epidural injection, a lumbar/cervical facet joint injection, a lumbar/cervical medial branch nerve block, a spinal cord stimulator trial, a spinal cord stimulator implant, a lumbar/cervical RFTC and a lumbar cervical discogram with CT scan. The utilization review physician cited the MTUS guidelines for chronic pain medical treatment and the ACOEM guidelines for low back complaints. On 2/26/15, the injured worker submitted an application for IMR for review of a lumbar epidural injection, a lumbar/cervical facet joint injection, a lumbar/cervical medial branch nerve block, a spinal cord stimulator trial, a spinal cord stimulator implant, a lumbar/cervical RFTC and a lumbar cervical discogram with CT scan.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Lumbar Epidural Steroid Injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

**Decision rationale:** MTUS recommends Epidural steroid injections (ESIs) as an option for short-term treatment of radicular pain, in conjunction with other rehabilitation efforts, including continuing a home exercise program. 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. Per MTUS, radiculopathy must be documented by physical examination and corroborated by imaging. No more than 2 Epidural steroid injections are recommended per current guidelines. A second epidural injection may be performed if there is partial success produced with the first injection, 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. The injured worker complains of chronic radicular low back pain and documentation shows objective findings of radiculopathy on physical examination corroborated by imaging. However, physician report at the time of the requested ESI indicates that the injured worker had received ESI less than 4 earlier with reported pain and functional improvement of up to 60%. Per MTUS, there should be continued improvement for up to 6-8 weeks prior to repeat epidural injection. Therefore, the request is not medically necessary by MTUS.

### **Lumbar/Cervical Facet Joint Injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Facet joint intra-articular injections (therapeutic blocks).

**Decision rationale:** MTUS does not support the use of Facet Joint Injections. ODG recommends Facet joint intra-articular injections (therapeutic blocks) at no more than 2 joint levels at any one time in patients with low-back pain that is non-radicular, with no spinal stenosis or previous fusion. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy and no more than one therapeutic intra-articular block is recommended. The injured worker complains of chronic radicular low back pain. Documentation shows objective findings of Lumbar spine radiculopathy. With regards to the cervical spine, physician reports fail to show objective findings of tenderness at the spinal

level under review. Therefore, the request is not medically necessary by lack of meeting guideline criteria.

**Lumbar/Cervical Facet Medial Branch Nerve Block (MBNB): 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): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Facet joint intra-articular injections (therapeutic blocks).

**Decision rationale:** MTUS does not support the use of Facet Joint Injections. ODG recommends Facet joint intra-articular injections (therapeutic blocks) at no more than 2 joint levels at any one time in patients with low-back pain that is non-radicular, with no spinal stenosis or previous fusion. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy and no more than one therapeutic intra-articular block is recommended. The injured worker complains of chronic radicular low back pain. Documentation at the time of the service under review shows objective findings of Lumbar spine radiculopathy. With regards to the cervical spine, physician reports fail to show objective findings of tenderness at the spinal level under review. Therefore, the request is not medically necessary by lack of meeting guideline criteria.

**Spinal Cord Stimulator Trial: 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), Neck & Upper back (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307, Chronic Pain Treatment Guidelines Spinal Cord Stimulators (SCS) Page(s): 105-107.

**Decision rationale:** Per MTUS, Implantable spinal cord stimulators are rarely used and should be reserved for patients with low back pain for more than six months duration that have not responded to the standard nonoperative or operative interventions. MTUS recommends Spinal cord stimulators for specific conditions such as Failed Back Surgery Syndrome (FBSS) and Complex Regional Pain Syndrome (CRPS) only for selected patients in cases when less invasive procedures have failed or are contraindicated and following a successful temporary trial. Although the injured worker has had back surgery, with chronic radicular low back pain, Physician reports show some response to other noninvasive treatment modalities including medication, physical therapy, chiropractic care and Epidural Steroid injection. Furthermore, documentation shows that the injured worker reports less pain with current treatment and continues to work with restrictions. The recommendation of a Spinal Cord Stimulator is subsequently not supported. With MTUS criteria not being met, the request is not medically necessary.

### **Spinal Cord Stimulator Implant: 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), Neck & Upper back (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307, Chronic Pain Treatment Guidelines Spinal Cord Stimulators (SCS) Page(s): 105-107.

**Decision rationale:** Per MTUS, Implantable spinal cord stimulators are rarely used and should be reserved for patients with low back pain for more than six months duration that have not responded to the standard nonoperative or operative interventions. MTUS recommends Spinal cord stimulators for specific conditions such as Failed Back Surgery Syndrome (FBSS) and Complex Regional Pain Syndrome (CRPS) only for selected patients in cases when less invasive procedures have failed or are contraindicated and following a successful temporary trial. Although the injured worker has had back surgery, with chronic radicular low back pain, Physician reports show some response to other noninvasive treatment modalities including medication, physical therapy, chiropractic care and Epidural Steroid injection. Furthermore, documentation shows that the injured worker reports less pain with current treatment and continues to work with restrictions. The recommendation of a Spinal Cord Stimulator is subsequently not supported. With MTUS criteria not being met, the request is not medically necessary.

### **Lumbar/Cervical RFTC: Upheld**

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

**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 Chapter, Facet joint radiofrequency neurotomy.

**Decision rationale:** Also called Facet rhizotomy, Radiofrequency medial branch neurotomy, or Radiofrequency ablation (RFA), this is a type of injection procedure in which a heat lesion is created on specific nerves to interrupt pain signals to the brain, with a medial branch neurotomy affecting the nerves carrying pain from the facet joints. ODG recommends the use of facet joint radiofrequency neurotomy when there is a diagnosis of facet joint pain using a diagnostic medial branch block. There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. Documentation fails to show evidence of a diagnostic medial branch block to support the diagnosis of facet joint pain as required for the recommendation of Radiofrequency ablation. Therefore, the request is not medically necessary per guidelines.

### **Lumbar/Cervical Discogram w/CT Scan: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 66, 178, 303, 304-5. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Low Back Chapter, ODG: Low Back Pain, Discography.

**Decision rationale:** MTUS states there is lack of strong medical evidence supporting discography and ODG does not recommend the procedure. Per guidelines, discography is considered a non-diagnostic but confirmatory study in the treatment of Chronic Low back pain for selecting operative levels for proposed surgical procedure. It is intended as screening tool to assist surgical decision making when there has been a failure of recommended conservative treatment including active physical therapy. It is not recommended for patients who do not meet surgical criteria. When performed, it should be reserved in cases where the patient has had back pain for at least 3 months, an MRI demonstrates one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection) and there has been satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided). Documentation reveals the injured worker has ongoing low back pain status post back surgery and is currently participating actively in Physical Therapy with less pain. Physician reports indicate that surgery is not being considered at the time of the requested service under review. Being that discography is not highly supported by MTUS or ODG and there is no evidence of planned surgery, the request is not medically necessary.