

Case Number:	CM14-0173108		
Date Assigned:	10/23/2014	Date of Injury:	05/04/2003
Decision Date:	11/25/2014	UR Denial Date:	10/09/2014
Priority:	Standard	Application Received:	10/17/2014

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 Anesthesiology and is licensed to practice in Tennessee, North Carolina, and Georgia. 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 62-year-old male who reported an injury on 05/04/2003. The mechanism of injury was not provided. The injured worker has diagnoses of lumbosacral strain and pre-existing degenerative disc disease of the lumbosacral spine, chronic pain syndrome, low back pain, history of L4-5 and L5-S1 fusion in 2008 and post-laminectomy syndrome. Past medical treatment included medications, chiropractic manipulation, physical therapy, a lumbar epidural injection in 2004 and facet injections in the past that provided greater than 50% relief of pain for 3 months. Diagnostic testing included lumbar x-rays 09/2000, 08/09/2005; an MRI of low back in 06/2003; a CT of lumbar spine without contrast done on 05/09/2013. Official report stated progressive degenerative changes and postoperative findings worsening stenosis at L4-5 and L5-S1; anterior interbody fusion between L4, L5 and S1; bilateral facet arthritis with hypertrophic change; L4-5 greater than L5-S1; and severe facet arthritis with hypertrophic growth at L3-4, especially on the right. Surgical history included significant left shoulder arthroscopy and resection of rotator cuff repair on 05/02/2012. The injured worker complained of low back pain that is more left sided than right sided on 08/08/2014. The injured worker described pain as constant, aching and sharp pains. The injured worker also complained of some numbness and tingling in the left inner thigh radiates down to leg. The pain is described as increased with activity and decreased with rest and medication. The injured worker rated his pain anywhere from an 8/10 to 10/10 without meds and down to 5/10 with medications. Physical examination of the lumbar spine revealed tender in lower back spine, the paraspinal muscles at L4-S1. On the range of motion, the injured worker is moderately diminished in all fields, has pain with forward flexion. Medications included Opana 30 mg every 12 hours, Norco 10/325 mg 6 a day and Voltaren gel. The treatment plan is for bilateral L3-4 facet injections under fluoroscopy guidance, quantity 1; bilateral L4-5 facet injections fluoroscopy guidance, quantity 1; conscious

sedation services; and retrospective request for Flexeril 10 mg #90 dispensed on 10/04/2014. The goal of the injections is to reduce the patient's pain and improve their function. The Request for Authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L3-4 facet injections under fluoroscopy guidance QTY: 1: 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), Facet Joint Intra-Articular Injections (Therapeutic Blocks)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Facet Joint Radiofrequency Neurotomy

Decision rationale: The injured worker complained of low back pain that is more left sided than right sided on 08/08/2014. The California ACOEM guidelines state facet injections are not recommended, there is limited research based evidence of patients with low back complaints. The Official Disability Guidelines (ODG) recommends that the clinical presentation should be consistent with facet joint pain signs & symptoms. The guidelines note facet injections are limited to patients with cervical pain/ lumbar that is non-radicular and at no more than two levels bilaterally. The guidelines recommend there should be documented evidence of failure of conservative treatment to include home exercise, physical therapy and non-steroidal anti-inflammatory drugs (NSAIDs), and no more than 2 joint levels should be injected in one session. There is lack of documentation with evidence of failed conservative treatment. There is a lack of documentation indicating facetogenic pain and there is a lack of documentation of a negative neurologic exam. The clinical documentation stated the injured worker has had facet injections in the past that provided greater than 50% relief for 3 months. However there is lack of documentation at what levels the injections were performed and date of injections. Therefore, the request for Bilateral L3-4 facet injections under fluoroscopy guidance QTY:1 is not medically necessary.

Bilateral L4-5 facet injections under fluoroscopy guidance QTY: 1: 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), Facet Joint Intra-Articular Injections (Therapeutic Blocks)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Facet Joint Radiofrequency Neurotomy

Decision rationale: The injured worker complained of low back pain that is more left sided than right sided on 08/08/2014. The California ACOEM guidelines state facet injections are not

recommended, there is limited research based evidence of patients with low back complaints. The Official Disability Guidelines recommend that the clinical presentation should be consistent with facet joint pain signs & symptoms. The guidelines note facet injections are limited to patients with cervical pain/ lumbar that is non-radicular and at no more than two levels bilaterally. The guidelines recommend there should be documented evidence of failure of conservative treatment to include home exercise, physical therapy and non-steroidal anti-inflammatory drugs (NSAIDs), and no more than 2 joint levels should be injected in one session. The included medical documents have no documented evidence of failed conservative treatment. There is a lack of documentation indicating facetogenic pain and there is a lack of documentation of a positive neurologic exam. The clinical documentation stated the injured worker has had Facet injections in the past that provided greater than 50% relief for 3 months. However, there is lack of documentation at what levels the injections were performed and date of injections. Therefore, the request for Bilateral L4-5 facet injections under fluoroscopy guidance QTY: 1 is not medically necessary.

Conscious sedation services QTY:1: 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), Facet Joint Intra-Articular Injections (Therapeutic Blocks)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Facet Joint Radiofrequency Neurotomy

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Retrospective request for Flexeril 10mg #90 dispensed on 10/4/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril), Muscle Relaxant Page(s): 41, 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 64.

Decision rationale: The injured worker complained of low back pain that is more left sided than right sided on 08/08/2014. The California MTUS Guidelines state that Flexeril is recommended for a short course of therapy. This medication is not recommended to be used for longer than 2-3 weeks. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The guidelines state Flexeril is not recommended for chronic pain or to be used for longer than 2-3 weeks. There is lack of documentation stating the length of time the injured worker has been prescribed the requested medication. There is a lack of evidence of muscle spasms documented upon physical examination. There is a lack of documentation of the physician's rationale for prescribing a muscle relaxant. The frequency of

the requested medication was not provided. Therefore, the request for Flexeril 10mg #90 is not medically necessary.