

<b>Case Number:</b>	CM13-0017874		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	02/15/2012
<b>Decision Date:</b>	12/24/2014	<b>UR Denial Date:</b>	08/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2013

### 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 Occupational Medicine and is licensed to practice in California. 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:

Injured worker is a female with date of injury 2/15/2012. Per primary treating physician's progress report dated 8/21/2013, the injured worker complains of neck and lower back pain. She reports constant pain in her neck travelling to her bilateral shoulders which she describes as burning and pressure. She rates her pain as 7/10. She reports constant pain in her lower back travelling to her left hip and left leg which she describes as pressure and sharp. She rates her pain as 7/10. She also complains of tingling in her left leg. Her pain is aggravated by prolonged sitting, prolonged standing, prolonged walking, repetitive bending, repetitive neck bending, repetitive lifting, repetitive carrying and cold weather. She has been receiving spinal decompression. She has been using a cervical pillow which is helpful. She states that she has been using hot/cold therapy which is helpful. On 8/12/2013 she underwent her second diagnostic lumbar epidural steroid injection and a lumbar facet joint block at the medial branch. The procedure helped to restore ability to function to the low back and reduced leg pain by one quarter. She states that the procedure improved her ability to perform the activities of daily living. Pain frequency is slightly less than before the procedures. Examination of the cervical spine reveals reflexes for the biceps are absent bilaterally and reflexes for the triceps and brachioradialis are diminished bilaterally. She has no loss of sensibility, abnormal sensation or pain in the anterolateral shoulder and arm on the right corresponding to the C5 dermatome. There is diminished sensation in the left C5-C8 dermatomes with normal sensation on the right. There is motor deficit noted that corresponds to the bilateral C5-C8 myotomes. Extension compression test, flexion compression test, Jackson's compression test and shoulder depressor test are positive bilaterally. Valsava's test is positive on the left and negative on the right. Range of motion in the cervical spine is normal. The thoracic spine reveals sensory deficit corresponding to the left T1 dermatome. There is motor deficit corresponding to the T1 myotomes bilaterally. Lumbar spine

reveals Bechterew's test, Kemp's test, heel walk and toe walk are positive on both sides. Valsalva is positive on the left and negative on the right. Extradural involvement/sciatic tension is positive bilaterally. Straight leg raise test for pain along the sciatic distribution is positive bilaterally. Reflexes for the knees are absent bilaterally and reflexes for the ankles are diminished bilaterally. There is sensory deficit noted in the left L2-S1 dermatomes. There is motor deficit corresponding to the L2-S1 myotomes bilaterally. Palpation reveals moderate tenderness on the left paraspinal muscles, facet joints, and sciatic nerve. Lumbar spine range of motion is normal. Diagnoses include 1) displacement of cervical intervertebral disc without myelopathy 2) brachial neuritis or radiculitis 3) degeneration of cervical intervertebral disc 4) spinal stenosis in cervical region C5-6 and C6-7 5) cervical facet joint syndrome 6) displacement of lumbar intervertebral disc without myelopathy L3-4 and L4-5 7) thoracic or lumbosacral neuritis or radiculitis 8) degeneration of lumbar or lumbosacral intervertebral disc 9) spinal stenosis L3-4 and L4-5 10) lumbar facet joint syndrome 11) headache 12) hypertension 13) psychosexual dysfunction 14) dysthymic disorder 15) insomnia.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **BILATERAL FACET JOINT BLOCK MEDIAL BRANCH L2-3, L3-4, L4-5: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back chapter, Facet Joint Diagnostic Blocks (Injections) section

**Decision rationale:** Per the MTUS Guidelines, facet-joint injections are of questionable merit. The treatment offers no significant long-term functional benefit, nor does it reduce the risk for surgery. The ODG recommends no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment. The clinical presentation should be consistent with facet joint pain, signs and symptoms. The procedure should be limited to patients with low-back pain that is non-radicular and no more than two levels bilaterally. There should be documentation of failure of conservative treatment, including home exercise, physical therapy and NSAIDs for at least 4-6 weeks prior to the procedure. No more than two facet joint levels should be injected in one session. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated or in patients who have had a previous fusion procedure at the planned injection level. Following the initial medial branch blocks and epidural steroid injections in 7/2013, the injured worker reported a reduction in pain from 7-8/10 to 5/10 which began three days after the procedure. Duration of pain reduction was not reported. Pain frequency was reported as slightly less than before, and function was reported as improved, but neither of these were described with any detail. This request is for a repeat block which is being provided without a facet neurotomy following the initial block. The injured worker is also reported to have radicular pain. Conservative treatment including exercise is not reported. This request is also for three levels, which is not recommended by the guidelines.

Medical necessity of this request has not been established. The request for bilateral facet joint block medial branch L2-3, L3-4, L4-5 is determined to not be medically necessary.

**LUMBAR ESI L3, L4 AND L4, L5:** Upheld

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

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

**Decision rationale:** The MTUS Guidelines recommend the use of epidural steroid injections (ESIs) as an option for treatment of radicular pain. Radicular pain is defined as pain in dermatomal distribution with corroborative findings of radiculopathy. Research has shown that less than two injections are usually required for a successful ESI outcome. A second epidural injection may be indicated if partial success is produced with the first injection, and a third ESI is rarely recommended. ESI can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The treatment alone offers no significant long-term functional benefit. Criteria for the use of ESI include radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, and failed conservative treatment. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medications use for six to eight weeks. Following the initial medial brach blocks and epidural steroid injections in 7/2013, the injured worker reported a reduction in pain from 7-8/10 to 5/10 which began three days after the procedure. Duration of pain reduction was not reported. Pain frequency was reported as slightly less than before, and function was reported as improved, but neither of these were described with any detail. No reduction in pain medication was reported. This request is for a repeat ESI which is being provided evidence of significant benefit from the initial ESI as described in the MTUS Guidelines. Medical necessity of this request has not been established. The request for LUMBAR ESI L3, L4 AND L4, L5 is determined to not be medically necessary.