

<b>Case Number:</b>	CM13-0018169		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	12/12/2012
<b>Decision Date:</b>	01/17/2014	<b>UR Denial Date:</b>	07/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas and New York. 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 physician 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.

### 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 patient is a 69-year-old female who reported a work related injury on 12/12/2012 due to unpacking boxes at work. The patient complained of low back pain. The patient underwent chiropractic treatment. MRI of the lumbar spine dated 01/31/2013 revealed an acute to subacute fracture at the S1 vertebral level; at the L4-5 disc space, there was anterolisthesis and subsequent bulge of the annulus and degenerative facet disease with hypertrophic change of the ligamentum flavum with moderate right and minimal left L4 lateral recess stenosis and minimal central canal stenosis with no foraminal stenosis. Hypertrophic change of the facet joints was also noted at the L3-4 space with foraminal stenosis at L2-3. Her diagnoses include spondylolisthesis of the lumbar spine, stenosis at L2 through L5, and multiple disc protrusions of the lumbar spine. The most recent office note dated 06/24/2013 revealed the patient complained of back pain rated 5/10 and indicated Celebrex and Zanaflex were helping. Examination revealed loss of lordosis and slight tenderness. It was recommended the patient remain off work and undergo facet joint injections and was prescribed Norco 5/325 to be taken as needed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient facet joint injections at L2, S1:** 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): 298-301.

**Decision rationale:** Recent clinical documentation submitted stated the patient complained of intermittent sharp pain to her lower back which is worse with activity, prolonged sitting, and repetitive movement. The patient denied having any numbness or tingling and on a bad day, she stated she took up to 3 Norco pills for pain. Objective findings included tenderness to palpation at L4 through S1. Straight leg raise was negative with a positive Lasegue's test. California Medical Treatment Guidelines indicate that invasive techniques such as local injections and facet joint injections of cortisone and Lidocaine are of questionable merit. The guidelines further state that despite the fact that proof is still lacking for injections, many pain physicians believe that diagnostic and/or therapeutic interventions may have benefit for patients that present in a transitional phase between acute and chronic pain. There is a lack of clinical documentation stating the patient had failed conservative care methods such as exercises, physical therapy, or treatment with NSAIDs. There is also a lack of objective findings on the patient's physical exam that support facet mediated pain at the requested L2 and S1 levels. As such, the request for outpatient facet joint injections at L2, S1 is non-certified.