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| Case Number: | CM13-0049426 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 02/18/2012 |
| Decision Date: | 02/25/2014 | UR Denial Date: | 11/04/2013 |
| Priority: | Standard | Application Received: | 11/07/2013 |

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 & Rehabilitation has a subspecialty in Interventional Spine 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 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. 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:

This patient reported a date of injury 02/18/2012. Per report 10/23/2013, the patient presents with chronic low back pain with radiation down the left lower extremity to the foot associated with weakness, muscle spasm, numbness and tingling. Pain is at 9/10 and has received some 5 epidural injections in the lumbar spine from 2012 with the last injection 09/12/2013. This resulted in increased pain for 2 to 3 days followed by a temporary relief for 1 week. Examination of the lumbar spine showed straight leg raise testing that is positive in supine position, 5-/5 muscle reflex on the left side, diminished range of motion. The listed diagnoses are lumbar disk bulges, central canal stenoses in multiple levels, foraminal stenoses at L3-L4, L4-L5, left S1 radiculopathy, lumbar spine spondylosis and disk collapse at L5-S1, status post left tarsal fracture, left knee sprain/strain. Under recommendation, the treating physician discusses total disk arthroplasty at L5-S1. Also reviewed his 09/10/2013 report by [REDACTED]. This is a handwritten report with patient experiencing chronic low back pain, pain radiating down the left leg, pain rated at 8/10. "States that injection has been helpful with improved function." Under treatment plan, there was a discussion of lumbar transforaminal epidural steroid injection at L4-L5. MRI of lumbar spine 08/02/2012 showed 4 to 5 mm posterior disk protrusion to the left at L5-S1, facet hypertrophy left more advance than the right. Including the reports are 2 operative reports, 06/05/2013 is for left lumbar facet injections from L2 to S1, and right lumbar facet injections from L3 to S1. Also, 02/06/2013, operative report for bilateral L3 to S1 medial branch blocks.

IMR ISSUES, DECISIONS AND RATIONALES

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

request for diagnostic lumbar facet joint injections at the levels of L4-L5 and L5-S1 under fluoroscopy.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG),

Decision rationale: This patient presents with chronic low back pain with radiating symptoms down the left lower extremity. MRI demonstrated 4 to 5 mm disk herniation over to left side. MRI is from 2012. The treating physician has requested repeat lumbar facet joint injections at L4-L5 and L5-S1 under fluoroscopy. Review of the reports showed that this patient has had what appears to be dorsal medial branch blocks at multiple bilateral levels on 02/06/2013 and 06/05/2013. Review of the reports show that the patient appear to have had monitored anesthesia and what the exact anesthetic agent is used is not provided. However, 0.5% Marcaine was injected at multiple levels on both sides in both of these operative reports. Following 02/06/2013 injection, [REDACTED] on 03/05/2013 progress report documents "60% to 70% relief" lasting for 2 to 4 days. This procedure was then repeated on 06/05/2013 and it appears that identical procedure was done at multiple levels on both sides. It is interesting to note that on this operative report, under indications, the treating physician reports "50% to 60% relief from prior procedure lasting 6 weeks." Followup progress report from 07/03/2013 indicates that from facet injections, the patient's experienced 75% reduction of pain from facet injections and that the pain is returning slowly. The patient's primary presenting symptoms are low back pain with radiating symptoms down the left lower extremity. The patient has had lumbar epidural steroid injections in the past. MTUS Guidelines do not discuss facet injections or facet evaluations. ACOEM Guidelines page 300 state invasive techniques, e.g., local injections, facet joint injections, or cortisone and lidocaine are of questionable merit. ACOEM Guidelines page 301 also states "lumbar facet neurotomies reproduce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks." For a more detailed discussion regarding facet joint evaluation and injections, ODG Guidelines has a specific criteria for performing diagnostic facet evaluations. In this guideline, the positive diagnostic block requires greater than 70% response and it should be limited to patient's with low back pain that is "non-radicular" and at no more than 2 levels bilaterally. In this patient, the patient clearly has radicular symptoms and facet joints should not be evaluated. There is a disk herniation at L5-S1 with clear radiating symptoms down the left lower extremity. The treating physician recognized this as a problem of radiculopathy where surgery is being recommended. There is no reason to perform facet diagnostic evaluation and introduce confusion into the diagnosis. ODG Guidelines do not support it. It should further be noted that patient did already have 2 dorsal medial branch diagnostic blocks. The treating physician reports 60% to 70% relief following the first one lasting 2 to 4 d