

<b>Case Number:</b>	CM14-0007522		
<b>Date Assigned:</b>	02/10/2014	<b>Date of Injury:</b>	07/02/2010
<b>Decision Date:</b>	07/21/2014	<b>UR Denial Date:</b>	01/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 patient is a 50-year-old female who has submitted a claim for lumbar degenerative disc disease, lumbar radiculopathy, and cervical degenerative disc disease associated with an industrial injury date of July 2, 2010. Medical records from 2012 to 2014 were reviewed. Patient complained of back pain, rated 9/10 in severity, and relieved to 7/10 upon intake of medications. She reported intermittent numbness to her left leg, 'pins-and-needles' sensation over the right leg, with burning pain downward from lumbosacral spine to bilateral groin area. She also reported loss of small amounts of urine occurring intermittently. Pain resulted to difficulty in sitting and standing. Patient reported benefits from medications, activity restrictions and rest. Physical examination of the lumbar spine revealed painful and restricted range of motion. Gower's sign was positive. Gait was antalgic and slow. Bilateral straight leg raise elicited calf pain bilaterally. Diminished sensation was noted at the left lateral leg and foot. Areflexia was noted at the left patella and left ankle. MRI of the lumbar spine, dated May 8, 2013, revealed disc bulge at L5 to S1; at L4-L5, mild left lateral and foraminal disc protrusion with minor anterolisthesis. Treatment to date has included lumbar epidural steroid injection, physical therapy, and medications such as Percocet, Celebrex, tramadol, and Zanaflex. Utilization review from January 17, 2014 denied the request for bilateral L4 to L5 ALAR S1 facet injection because the patient presented with overt radiculopathy which is a contraindication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**BILATERAL L4-5 ALAR S1 FACET INJECTIONS:** 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) Low Back Chapter.

**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 Section, Facet Joint Block.

**Decision rationale:** Page 300 of CA MTUS ACOEM Guidelines supports facet injections for non-radicular facet mediated pain. In addition, ODG criteria for facet injections include documentation of low-back pain that is non-radicular, failure of conservative treatment (including home exercise, PT, and NSAIDs) prior to the procedure for at least 4-6 weeks, no more than 2 joint levels to be injected in one session, and evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint therapy. In this case, patient complained of back pain associated with numbness and 'pins-and-needles' sensation at bilateral lower extremities. This was corroborated by positive bilateral straight leg raise, and diminished sensation and areflexia at left lower extremity. Patient's manifestations are consistent with radiculopathy. Diagnoses includes lumbar radiculopathy at L4-L5. However, presence of radicular pain is not an indication for facet blocks as stated above. Guideline criteria were not met. Moreover, the most recent progress report from 1/22/14 revealed that treatment plan is lumbar epidural steroid injection at L4 to L5, and not facet block injection. Therefore, the request for BILATERAL L4-5 ALA S1 FACET INJECTIONS is not medically necessary.