

Case Number:	CM14-0100476		
Date Assigned:	07/30/2014	Date of Injury:	04/05/2012
Decision Date:	10/09/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/30/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Texas and Oklahoma. 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 60-year-old female with a reported date of injury on 04/05/2012. Her diagnoses were noted to include lumbar facet syndrome, lumbar radiculopathy, and low back pain. Her previous treatments were noted to include facet injection, home exercise program, TENS unit, and medications. The unofficial MRI report dated 07/16/2012 revealed L4-5 bilateral facet joint effusions with 4 mm facet gaps and moderate facet arthropathy with mild disc spur complex, contributing to moderate, central, and foraminal stenosis. The L5-S1 had severe facet and ligament flava hypertrophy with bilateral facet joint effusions. 3 mm right facet gap, 1 mm left facet gap, epidural lipomatosis narrow to the thecal sac with no significant central stenosis. 2 mm to 3 mm broad based/protrusion into the right foramen contacting the exiting L5 nerve root, but not impinging it. Mild left foraminal stenosis. The progress note dated 04/09/2014 revealed complaints of low back pain that had increased since her last visit. The injured worker reported increased pain in her left buttocks and swelling, as well as numbness to her left leg. She reported poor quality of sleep, and that her low back pain had increased on the left side. The injured worker indicated she was interested in repeat facet injections/aspiration due to increased pain and her previously injection from 01/2014 gave her significant relief for several weeks. The physical examination to the lumbar spine revealed restricted range of motion, and upon palpation, the paravertebral muscles had spasms and tight muscle banding and trigger points to the left side. Lumbar facet loading was positive on the left side. The straight leg raise test was positive on the left side. There was significant left lumbar facet loading, dysesthesias with palpation to the left lumbar region, and tenderness noted over the sacroiliac spine. Trigger point with radiating pain and twitch response upon palpation at the lumbar paraspinal muscles on the right and left. The motor strength examination revealed decreased motor strength to the EHL rated 4/5 on the left and plantar flexes on the left, as well as the hip

flexors were -5/5 on the right/left. The provider indicated the injured worker was status post a lumbar facet injection from the L4-5 and L5-S1 to the left side 01/21/2014, and received greater than 50% improvement in pain, and her activity had increased and had been able to take less medication. The progress note dated 05/07/2014 revealed complaints of low back pain and decreased activity level. The injured worker continued to complain of left lumbar pain and rated her pain 6/10 without medications, and with medications 2/10. The physical examination revealed decreased range of motion, limited by pain, and paravertebral muscle spasms, tight muscle banding, and trigger points along the left side. There was a positive lumbar facet loading on the left side and a negative straight leg raise. There was significant left lumbar facet loading dysesthesias with palpation to the left lumbar region, and tenderness noted over the sacroiliac spine. The trigger points were noted with radiating pain and twitch response upon palpation at the lumbar paraspinal muscles on the right and left. The inspection of the left hip joint revealed tenderness over the sacroiliac joint, a positive left Fortin's, Gaenslen's, sheer, faber, and Gaenslen's. The faber test was positive. The motor examination revealed decreased motor strength. The Request for Authorization form dated 06/09/2014 was for a lumbar facet joint injection at L4-5 and L5-S1 joints to the left side for left facet pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar facet joint injection, L4-L5, L5-S1, joints 2; side: left: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG: Low Back; Facet joint intra-articular injections

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Facet joint intra-articular injections.

Decision rationale: The request for Lumbar facet joint injection, L4-L5, L5-S1, joints 2; side: left is not medically necessary. The injured worker received a previous lumbar facet joint injection to the L4-5 and L5-S1 and received greater than 50% pain relief for several weeks. The Official Disability Guidelines state facet joint intra-articular injections are under study. The current evidence is conflicting as to this procedure and at this time, no more 1 therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy. If a therapeutic facet joint block is undertaken, it is suggested that it be used in concert with other evidence based conservative care, such as activity and exercise to facilitate functional improvement. The guidelines criteria for the use of therapeutic intra-articular and medial branch blocks are no more than 1 therapeutic intra-articular block is recommended. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. If successful (initial pain relief of 70%, plus pain relief of at least 50% of a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy. No more than 2 joint levels may be blocked at one time and there should be evidence of a formal plan of additional evidence based activity and exercise in addition to the facet joint injection

therapy. The documentation provided indicated the injured worker had greater than 50% pain relief for several weeks; however, it did not specify 6 or more weeks of pain relief. The lumbar spine MRI showed central and foraminal stenosis to the L4-5 and L5-S1 regions and the guidelines state there should be no evidence of radicular pain, spinal stenosis, or previous fusion. The documentation provided indicated there were positive trigger points with radiating pain, as well as a positive straight leg raise test. Therefore, due to positive radicular symptoms and positive central canal and foraminal stenosis by MRI, and a lack of documentation regarding number of weeks of pain relief with previous facet injection, a repeat facet injection is not appropriate at this time. As such, the request is not medically necessary.