

<b>Case Number:</b>	CM14-0181123		
<b>Date Assigned:</b>	11/05/2014	<b>Date of Injury:</b>	01/15/2003
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2014

### 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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 74-year-old man, with cardiac issues, who sustained a work related injury on January 15, 2003. Subsequently, he developed chronic neck and back pain. The patient underwent laminectomy L2, L3, L4, and L5 with hemilaminectomy at S1 with surgery performed on October 9, 2006. MRI of the cervical spine dated in April 2008 showed evidence of multilevel cervical disc disease. MRI of the lumbar spine performed on January 17, 2008 documented evidence of degenerative disease without findings of spinal stenosis. Treatment history included facet injections bilaterally at L3-4, L4-5, and L5-S1 (performed on February 10, 2014), topical medications, caudal epidural steroid injection, and physical therapy. According to a comprehensive evaluation report dated November 11, 2014, the patient complained of back, neck, leg, and feet pain, he stated the treatment he is receiving makes the pain better and walking and sitting makes the pain worse. Examination of the lumbar spine revealed no evidence of scoliosis. On palpation, there was no muscle spasm over the paravertebral area, bilaterally. There was no muscle spasm in the sacroiliac joint areas. There was no muscle spasm over the piriformis tendon. There was localized tenderness over the midline at L5. Gait was normal. Heel walking was normal. Toe walking was normal. There was pain of both feet at the ball of the foot on heel walking. The Burns and Hoover tests were negative. The range of motion was restricted by pain. The patellar and Achilles reflexes were normal bilaterally. Sensation was intact throughout the L3, L4, L5, and S1 areas, bilaterally. The Babinski's sign was negative, bilaterally. There was no clonus. Straight leg raise in the supine and sitting positions were negative, bilaterally. The Patrick Fabere test was negative, bilaterally. Diagnoses have included: cervical spine strain/sprain with cervical disc disease, lumbar disc disease, and lumbar strain/sprain. The provider requested authorization for bilateral lumbar epidural injections at L4-5 and Bilateral lumbar facet block injections at L4-5 under fluoroscopy.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Bilateral lumbar epidural injections at L4-5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** According to MTUS guidelines, epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit however there is no significant long term benefit or reduction for the need of surgery. Furthermore, the patient file does not document that the patient is candidate for surgery. In addition, there is no recent clinical and objective documentation of radiculopathy. There is no clear and recent documentation of failure of oral pain medications. MTUS Guidelines does not recommend epidural injections for back pain without radiculopathy (309). There is no documentation of the efficacy of previous epidural steroid injection. Therefore, the request for bilateral lumbar epidural injections at L4-5 is not medically necessary.

### **Bilateral lumbar facet block injections at L4-5 under fluoroscopy:** 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), Treatment Index, 12th Edition (web0, 2014 Low back - facet joint Intra-articular injections (therapeutic blocks); Facet joint pain, signs & symptoms

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** According MTUS Guidelines, Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain. According to ODG Guidelines regarding facets injections: Under study. Current evidence is conflicting as to this procedure and at this time no more than one 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 the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001)

(Manchikanti, 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial. Furthermore and according to ODG guidelines, Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: 1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. If successful (initial pain relief of 70%, plus 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 the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time. 5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. In this case, there is no documentation of facet mediated pain. There is no clear evidence or documentation that lumbar and sacral facets are main pain generator. There is no documentation of the efficacy of previous facet injections. Therefore bilateral lumbar facet block injections at L4-5, under fluoroscopy, are not medically necessary.