

<b>Case Number:</b>	CM14-0064301		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	07/29/2006
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	04/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2014

### 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 Occupational Medicine, 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 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 claimant injured her cervical and lumbar spines on 07/29/06. Lumbar facet injections at 2 levels bilaterally and cervical epidural steroid injection at C4-5 are under review. The claimant saw [REDACTED] on 04/04/14 for follow-up. She is status post cervical fusion at C5-6 and recent x-rays showed degenerative disc disease at the level above her previous fusion. She remained severely symptomatic with low back pain. Diagnostic lumbar facet joint injections were recommended. She continued to require medications for pain. Her pain level was 6-7/10. She was taking Percocet, Soma, Lyrica, and Lunesta. She had moderate muscular spasm and guarding over the paraspinal muscle and bilateral gluteus region. There was moderate tenderness at multiple vertebral levels. She had focal tenderness of the facet joints. There was moderate muscular spasm and guarding. Manual muscle testing revealed mild weakness on knee flexion and extension and at the ankle. She is status post cervical fusion with chronic neck pain and cervical radiculopathy. She also has multilevel lumbar disc desiccation and facet hypertrophy and lumbar radiculopathy with chronic pain and depression. A recent MRI revealed hypertrophic changes at facet joints at multiple levels. A trial of facet injections was requested. A trial of cervical epidural injection was recommended above her previous fusion. Recent x-rays revealed degenerative disc disease at C4-5 with radicular condition. She has residuals of her ACDF. No myelopathy was noted in July 2012 by [REDACTED]. She has had extensive treatment and imaging studies to date. She saw [REDACTED] for an initial pain management evaluation on 10/01/13. She had persistent neck pain with upper extremity radiation and low back pain with bilateral lower activity radiation worse on the right side. She underwent cervical fusion from C5-7 in January 2007 but remained symptomatic. She also had chronic depression. She complained of low back pain in the posterior neck area and upper back with shooting sensations in the upper extremities. She reported numbness, tingling, and weakness. She had constant low

back pain that was localized to the lumbar area moreso on the right side. She also had a shooting sensation into her lower extremities moreso on the right side with numbness and tingling. She used a cane for ambulation. Deep tendon reflexes were decreased at the bilateral ankles. She had moderate tenderness. There was mild weakness in the lower extremities. Sensation was intact. Straight leg raise was positive bilaterally at 40-50. On 01/21/14, she saw [REDACTED] again. She remained severely symptomatic with worsening pain and had radiculopathy to her upper and lower extremities. She had tenderness about the cervical and lumbar paraspinal muscles and over the bilateral upper trapezius regions. There was tenderness at the cervical and lumbar vertebra. She had mild weakness in all of her extremities. There was no sensory deficit. Straight leg raises were positive bilaterally but were not fully described. An updated MRI of the lumbar spine is recommended. On 02/18/14, she was seen again. She still had lumbar radiculopathy her findings were essentially unchanged. Her neck symptoms were not described at that time. On 04/04/14, she was seen again. She remained severely symptomatic from her low back pain. Again her cervical spine was not described. A trial of cervical epidural steroid injections and lumbar facet joint injections were recommended. She had an MRI of the lumbar spine on 02/09/14 that revealed multilevel disc desiccation with hypertrophic changes of the facet joints. There was pressure over the transiting L5 nerve root at level L4-5. There were other findings, also. On 05/02/14, [REDACTED] appealed the denial for the facet injections and epidural injections. He stated that she has degenerative disease and a cervicogenic and radicular condition and diagnostic epidural steroid injection at C5-6 was clearly supported. He also stated she had moderate to severe facet joint arthropathy at L4-5 and L5-S1 and facet joint injections were again recommended.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **1 lumbar facet injection bilateral L4-5 and L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection.

**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 Injections.

**Decision rationale:** The history and documentation do not objectively support the request for bilateral lumbar facet injections at L4-5 and L5-S1. The MTUS do not address facet injections and the ODG state re: facet injections "recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study").... Criteria for the use of diagnostic blocks for facet "mediated" pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session

(see above for medial branch block levels).5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.7. Opioids should not be given as a "sedative" during the procedure.8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)]"In this case, the claimant has been described as having a diagnosis of chronic pain with radiculopathy which is a contraindication for the use of facet injections. She has pain in her legs and not just axial pain. As a result, the medical necessity of the request for bilateral facet injections for the lumbar spine at levels L4-5 and L5-S1 has not been clearly demonstrated.

### **1 cervical epidural steroid injection at C4-5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 79.

**Decision rationale:** The history and documentation do not objectively support the request for a cervical spine ESI at this time. The MTUS state "ESI may be recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy).... Criteria for the use of Epidural steroid injections: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)...."There is no clear objective evidence of radiculopathy at level C4-5 on physical examination and no EMG was submitted. There is no evidence that the claimant has completed or attempted and failed a conservative course of treatment for her radicular symptoms or whether or not she has been involved in an ongoing exercise program since her surgery. There is no indication that he has failed all other reasonable conservative care, including PT and trials of medications and local care, or that this ESI is based on an attempt to avoid surgery. There is no MRI report indicating the presence of nerve root compression at the level to be injected. In addition, [REDACTED], in his appeal letter, mentioned a diagnostic ESI at level C5-6, not C4-5. There is no indication that the claimant has been instructed in home exercises to do in conjunction with injection therapy. The medical necessity of this request for a cervical spine ESI at level C4-5 has not been clearly demonstrated.

