

<b>Case Number:</b>	CM14-0086049		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	12/29/1997
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	06/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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, 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 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 55-year-old male with date of injury of 12/29/1997. The listed diagnoses per [REDACTED] dated 04/24/2014 are: 1. Chronic pain syndrome. 2. History of lumbar fusion and hardware removal with chronic back pain. 3. Chronic neuropathic pain in bilateral lower extremities. 4. Cervical radiculitis; has had epidural injections in the past with benefit. According to this report, the patient has history of lumbar fusion with chronic back pain and neuropathic pain in the bilateral lower extremities. The patient also has cervical radiculitis. He continues to have constant aching, sharp pain in the back that intermittently radiates down the posterior legs and bilaterally to his calves. He also has neck pain that increases with activity and, at times, some pain in the left proximal arm. The physical exam shows that the patient is able to ambulate independently. Strength and sensation are normal in the upper extremities. No pathological reflexes were noted. The back exam shows painful range of motion in all planes. Reflexes are brisk at the knee and ankle, but no pathological reflexes were noted. Negative straight leg raise test bilaterally. The utilization review denied the request on 06/02/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Facet Steroid Injections:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines have the following regarding Facet joint signs and symptoms: Recommended as outlined in specific sections: Facet joint diagnostic blocks; Facet joint radiofrequency neurotomy; & Facet joint therapeutic steroid injections. The cause of this condition is largely unknown although pain is generally thought to be secondary to either trauma or a degenerative process. Traumatic causes include fracture and/or dislocation injuries and whiplash injuries, with the most common cervical levels involved in the latter at C2-3 and C5-6. (Lord 1996) (Barnsley, 2005). The condition has been described as both acute and chronic, and includes symptoms of neck pain, headache, shoulder pain, suprascapular pain, scapular pain, and upper arm pain. (Clemans, 2005)Symptoms: The most common symptom is unilateral pain that does not radiate past the shoulder. (van Eerd, 2010)Physical findings: Signs in the cervical region are similar to those found with spinal stenosis, cervical strain, and diskogenic pain. Characteristics are generally described as the following: (1) axial neck pain (either with no radiation or rarely past the shoulders); (2) tenderness to palpation in the paravertebral areas (over the facet region); (3) decreased range of motion (particularly with extension and rotation); & (4) absence of radicular and/or neurologic findings. If radiation to the shoulder is noted pathology in this region should be excluded. (Fukui, 1996) (van Eerd, 2010) (Kirpalani, 2008)Diagnosis: There is no current proof of a relationship between radiologic findings and pain symptoms. The primary reason for imaging studies is to rule out a neurological etiology of pain symptoms. Diagnosis is recommended with a medial branch block at the level of the presumed pain generator/s. (Kirpalani, 2008)See Facet joint diagnostic blocks; Facet joint radiofrequency neurotomy; Facet joint therapeutic steroid injections. Facet diagnostics: Recommended prior to facet neurotomy (a procedure that is considered "under study"). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBB. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 27% to 63%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. Technique: The described technique of blocking the medial branch nerves in the C3-C7 region (C3-4, C4-5, C5-6, and C6-7) is to block the named medial branch nerves (two injections). Authors have described blocking C2-3 by blocking the 3rd occipital nerve. Another technique of blocking C2-3 is to block at three injection points (vertically over the joint line, immediately above the inferior articular facet at C2 and immediately below the superior articular facet at C3). (Barnsley, 1993) The medial branch nerve innervates the facet joint, facet capsular ligaments, the interspinous and supraspinous ligaments, spinous processes and paraspinal muscles. Relief of pain could be due to blockade of nociceptive input from any combination of these. It is suggested that the volume of injectate for diagnostic medial branch blocks be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate) as increased volume may anesthetize.

**Decision rationale:** This patient presents with chronic low back pain. The treater is requesting a bilateral facet steroid injection, but the progress report and the request for authorization form containing the request are missing. The ACOEM Guidelines do not support facet injection for treatments but does discuss dorsal medial branch blocks as well as radiofrequency ablation. ODG

Guidelines also support facet diagnostic evaluations for patients presenting with paravertebral tenderness with non-radicular symptoms. No more than 2 levels bilaterally are recommended. The report dated 04/24/2014 shows normal sensation and strength in the upper extremities. The records do not show that the patient has had any previous facet steroid injection. The procedure report dated 06/23/2014 documents a cervical facet steroid injection at C4-5 and C5-6. It appears that the treater went ahead with the procedure, despite utilization review letter of denial from 6/2/14. In this case, the physical exam on 04/24/2014 does not show paravertebral tenderness. There is reference to cervical ESI with benefit which would indicate that the patient presents with radicular symptoms for which facet injections are not supported. Recommendation is for denial.