

<b>Case Number:</b>	CM14-0195966		
<b>Date Assigned:</b>	12/03/2014	<b>Date of Injury:</b>	02/04/2002
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	11/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/23/2014

### 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:

This 60 year old woman sustained an industrial injury on 2/4/2002, resulting in lumbar spondylosis and lumbar radiculopathy. Treatment has included a cervical fusion in 2008, physical therapy, TENS unit, lumbar facet injections, radiofrequency ablation to L3 and L4 and then to L4 and L5, trigger point injections, repeat radiofrequency ablations in 2013 and 2014, chiropractic treatment, and oral medications. The worker has undergone EMG/NCV in 2012, MRI lumbar spine in 2012 which showed a 5mm right disc protrusion at L5-S1 with right greater than left SI nerve root impingement and right L5 nerve root impingement, and a posterior facet arthropathy right greater than left 3mm focal central disc herniation at L4-L5 without spinal stenosis or foraminal narrowing. Physician notes from 10/23/2014 state that the worker's current pain level is 7-8/10 with an average of 5-6/10. There is restricted flexion with pain, a 45 degree right rotation, 30 degrees left rotation, normal lower extremity strength, and decreased sensation to the right lower extremity. The physician agreed that the facet injection would be successful and appropriate and requested authorization for bilateral facet injections to L3, L4, and L5. On 11/3/2014, Utilization Review evaluated prescription for bilateral facet joint injections at L3, L4, and L5. The physician noted that the worker has had this procedure in the past with documentation of pain relief "right away"; however, it is unclear how long the pain relief lasted. Also noted is that radiofrequency ablation was approved on 10/16/2014 for bilateral L4-L5; however, the worker is now refusing this procedure due to the invasiveness. The request was denied and subsequently appealed to Independent Medical Review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Bilateral facet joint injections at L3, L4, L5: 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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), facet injections

**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. The ODG guidelines do not support facet injection for lumbar pain in this clinical context. There is no documentation of facet mediated pain or that facets are the main pain generator. There is no documentation of failure of conservative therapies in this patient. There is no documentation of sustained pain and functional improvement with previous lumbar facet injection. Therefore, the request for Bilateral facet joint injections at L3, L4, L5 is not medically necessary.