

<b>Case Number:</b>	CM14-0202083		
<b>Date Assigned:</b>	12/12/2014	<b>Date of Injury:</b>	05/24/2001
<b>Decision Date:</b>	01/31/2015	<b>UR Denial Date:</b>	11/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2014

### 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 30-year-old woman who sustained a work related injury on May 24, 2001. Subsequently, she developed a chronic left knee pain. Electrodiagnostic studies were performed on March 11, 2013 and demonstrated abnormal study. There was Electrodiagnostic evidence of right L5 and S1 radiculopathies. There was no Electrodiagnostic evidence of a right lower extremity plexopathy or mononeuropathy. The patient underwent a right L5-S1 interlaminar epidural injection on June 18, 2014 (the pain became worse after the procedure) and a bilateral L3-4-5 medial branch blocks on July 9, 2014. The patient underwent facet injections and sustained a 70% pain relief with duration being intermittent. An MRI of the lumbar spine was performed on September 8, 2014 showing a small central disc protrusion at L5-S1 without definite nerve root impingement. Mild foraminal narrowing at L4-5 and L5-S1. A peer review was performed on September 9, 2014 and a non-certification was rendered for the requested lumbar facet injection using fluoroscopy, bilateral L4, L5, and S1. It was determined that the patient should be absent of radicular findings on examination. The patient had radicular clinical findings on examination and thus facet injections would not be indicated. A subsequent peer review was performed on October 1, 2014, at which time a recommendation was given to non-certify the appeal for lumbar facet injection using fluoroscopy or ultrasonic bilateral L4, L5, and S1. According to a progress report dated October 27, 2014, the patient complained of lumbar and right leg pain. The patient rated her level of pain as an 8/10 with medications. The patient described symptoms as worsening and medications were no helpful. Upon examination, lumbar extension reproduced pain. There was tenderness over the lower lumbar facets Forward flexion was mildly uncomfortable as well. 4-5/5 strength in right knee flexion, extension, right foot dorsiflexion, and plantar flexion. There was altered sensation in the right L5 and S1 dermatomes and positive bowstring sign on the right. The patient was diagnosed with chronic back pain,

lumbar radiculopathy (supported by EMG and MRI), lumbar disc displacement, and lumbar spondylosis. The provider requested authorization for Bilateral lumbar facet injections L3, L4, L5.

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

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

#### **Bilateral lumbar facet injections L3, L4, L5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 309. Decision based on Non-MTUS Citation Official Disability Guidelines ([http://www.odg-twc.com/odgtwc/low\\_back.htm](http://www.odg-twc.com/odgtwc/low_back.htm))

**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, the 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 did 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. No more than 2 joint levels may be blocked at any one time. The provider is requesting to inject 3 level. Therefore, the request for Bilateral facet injections at L3, L4, L5 is not medically necessary.