Case Number:	CM14-0208133		
Date Assigned:	12/22/2014	**Date of Injury:**	03/21/2014
Decision Date:	02/18/2015	**UR Denial Date:**	11/17/2014
Priority:	Standard	**Application Received:**	12/12/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: New Jersey, Michigan, California
Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 52-year-old woman who sustained a work-related injury on March 21, 2014. Subsequently, she developed chronic low back pain. Prior treatments included: 3 sessions of physical therapy, chiropractic treatment (did not help), use of a stationary bike that exacerbated the pain, and 4 trigger point injections on September 24, 2014 with reported good pain relief of more than 50% and increased range of motion a few minutes after the injection. MRI of the lumbar spine dated July 10, 2014 showed disc desiccation at L4-5 through L5-S1. There was a broad-based posterior disc herniation at L4-5, which caused stenosis of the spinal canal and the bilateral neuroforamen. The disc measured 3.8 mm. There was a broad-based disc herniation at L5-S1, which caused stenosis of the spinal canal and bilateral neuroforamen. EMG/NCV of the lower extremities performed on August 4, 2014 revealed normal study. According to a progress report dated December 1, 2014, the patient continued to complain of constant low back pain and frequent debilitating spasms. The pain radiated into bilateral lower extremities with numbness, tingling, and stiffness. She also complained of pain of lower extremity with the left greater than right. She stated her pain and spasms have worsened as authorization for the previously requested physical therapy and acupuncture treatment has not been provided. She has been authorized for lumbar epidural steroid injections and is pending scheduling. Thoracolumbar spine examination revealed positive paravertebral muscle spasm bilaterally. Lumbar spine range of motion was limited by pain. There was positive straight leg raising at 45 degrees bilaterally. Bargard's, Valsalva, and Kemp's tests were positive bilaterally. Deep tendon reflexes lower extremities were +2 bilaterally. Motor strength of the hips was 5/5 on the right and 4/5 on the

left. The patient was diagnosed with lumbar spine herniated nucleus pulposus with radiculopathy, left shoulder post surgical repair x2, stress, anxiety, and depression. The provider requested authorization for lumbar facet injections bilateral L4-5 and L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Facet Injections Bilateral L4-5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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, 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 docmentation of facet mediated pain. There is no evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. MTUS guidelines do not recommend facet injection if there is suspicion of radiculopathy. The patient in this case has

radicular pattern of pain with positive straight leg raise and sensory evaluation. Therefore, the request for lumbar facet injections bilateral L4-5 and L5-S1 is not medically necessary.