

<b>Case Number:</b>	CM15-0106906		
<b>Date Assigned:</b>	06/11/2015	<b>Date of Injury:</b>	02/28/2003
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/03/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 injured worker is a 62 year old male, who sustained an industrial injury on 02/28/2003. He has reported subsequent low back pain and was diagnosed with lumbago and lumbar degenerative joint disease. Treatment to date has included oral pain medication, manual therapy and surgery. In a progress note dated 04/21/2015, the injured worker complained of low back pain that was rated as 7/10. Objective findings were notable for limited extension of the lumbar spine, positive Patrick's, FABER's, Flamingo and Gaenslen's tests and tenderness to palpation of the lumbar facet joints and paraspinal musculature. A request for authorization of facet joint injections at bilateral L4-L5 and L5-S1 under IV sedation, bilateral SI joint injections under IV sedation and MRI of the lumbar spine was submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Facet joint injections at bilateral L4-5, L5-S1 under IV sedation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, facet injections.

**Decision rationale:** The ACOEM states: 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. Per the ODG, facet joint injections are under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are currently not recommended as a treatment modality in most evidence based reviews as their benefit remains controversial. Criteria for use of diagnostic blocks for facet nerve pain: 1. One set of diagnostic medial branch blocks is required with a response of 70%; 2. Limited to non-radicular cervical pain and no more than 2 levels bilaterally; 3. Documentation of failure of conservative therapy; 4. No more than 2 joint levels are injected in 1 session; 5. Diagnostic facet blocks should be performed in patients whom a surgical procedure is anticipated. The requested service is not recommended per the ACOEM or the Official Disability Guidelines. Criteria have not been met in the provided clinical documentation and the request is not medically necessary.

**Bilateral SI joint injections under IV sedation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, sacroiliac joint injections.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested service. The ODG states sacroiliac joint injections are only indicated when the patient has failed 4-6 weeks of aggressive conservative therapy with clear physical finding consistent with sacroiliac etiology of pain. These criteria are not met in the provided clinical documentation and therefore the request is not medically necessary.

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-308.

**Decision rationale:** The ACOEM chapter on low back complaints and special diagnostic studies states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore the request is not medically necessary.