

Case Number:	CM15-0024948		
Date Assigned:	02/17/2015	Date of Injury:	07/31/2007
Decision Date:	03/30/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/09/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 49 year old female, who sustained an industrial injury on 07/31/2007. She has reported low back pain. The diagnoses have included lumbar degenerative disc disease; lumbosacral spondylosis, and lumbar radiculopathy. Treatment to date has included medications, lumbar facet joint injection, and physical therapy. Medications have included Norco. Currently, the injured worker complains of lumbar back pain radiating into both lower extremities; pain is described as aching, constant, and dull; increased back pain that is in the right buttock, not going below the mid posterior thigh; and pain is rated at 7/10 on the visual analog scale. A progress report from the treating physician, dated 01/16/2015, included objective findings consisting of moderate tenderness to palpation of the lower lumbar spine; moderately decreased lumbar range of motion; and left and right facet load (Kemps test) are positive. The treatment plan included continuation with physical therapy and pain medication; and request for lumbar facet joint injection bilaterally at L4-L5 and L5-S1. On 01/26/2015 Utilization Review noncertified a prescription for Lumbar Facet Joint Injection, Bilateral L4-L5; and noncertified a prescription for Lumbar Facet Joint Injection, Bilateral L5-S1. The CA MTUS, ACOEM Guidelines and the ODG were cited. On 02/06/2015, the injured worker submitted an application for IMR for review of Lumbar Facet Joint Injection, Bilateral L4-L5; and Lumbar Facet Joint Injection, Bilateral L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Facet Joint Injection, Bilateral L4-L5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Facet Joint Therapeutic Steroid Injection, Neck, and Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic (Acute & Chronic), Facet joint diagnostic blocks (injections) Other Medical Treatment Guideline or Medical Evidence: MD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections

Decision rationale: ACOEM Guidelines state 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. MTUS is silent specifically with regards to facet injections, but does refer to epidural steroid injections. ODG and MD Guidelines agree that: One diagnostic facet joint injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments (e.g., NSAIDs, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended. If after the initial block/blocks are given (see Diagnostic Phase above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. ODG details additional guidelines: Clinical presentation should be consistent with facet joint pain, signs & symptoms.1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine.2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.7. Opioids should not be given as a sedative during the procedure.8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require

UR physician review: Previous fusion at the targeted level. Treatment notes did not detail conservative treatment failures that are outlined in the guidelines above. As such, the request for Lumbar Facet Joint Injection, Bilateral L4-L5 is not medically necessary.

Lumbar Facet Joint Injection, Bilateral L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Facet Joint Therapeutic Steroid Injection, Neck, and Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic (Acute & Chronic), Facet joint diagnostic blocks (injections) Other Medical Treatment Guideline or Medical Evidence: MD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections

Decision rationale: ACOEM Guidelines state 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. MTUS is silent specifically with regards to facet injections, but does refer to epidural steroid injections. ODG and MD Guidelines agree that: One diagnostic facet joint injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments (e.g., NSAIDs, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended. If after the initial block/blocks are given (see Diagnostic Phase above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. ODG details additional guidelines: Clinical presentation should be consistent with facet joint pain, signs & symptoms.1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine.2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.7. Opioids should not be given as a sedative during the procedure.8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated.

(Resnick, 2005)¹¹. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. The treating physician does not provide objective or subjective findings to detail other conservative treatment failures, outlined in the guidelines above. As such, the request for Lumbar Facet Joint Injection, Bilateral L5-S1 is not medically necessary.