

Case Number:	CM15-0029834		
Date Assigned:	02/23/2015	Date of Injury:	06/10/2006
Decision Date:	04/07/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/17/2015

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: 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:

This 65-year-old female sustained a work related injury on 06/10/2006. According to a progress report dated 12/08/2014, the injured worker complained of chronic symptoms of lower back pain. Physical examination demonstrated normal gait and diffuse tenderness to palpation of the quadratus lumborum and erector spinae muscles bilaterally. Lumbar range of motion was approximately 80 percent of expected normal range in all planes without rigidity. Diagnoses included chronic isolated lower back pain with intermittent radiation into the left lower extremity. Clinical evidence of lumbar facet joint syndrome and intermittent left lumbar radiculopathy was noted. MRI of the lumbar spine on 05/20/2013 showed multilevel degenerative spondylosis with severe neuroforaminal stenosis on the right at L3-4 and L4-5 and severe left neuroforaminal stenosis at L5-S1. Electrodiagnostic testing on 09/19/2014 demonstrated normal nerve conduction and electromyography study of the lower extremities; clinical correlation was indicated. On 02/04/2015, Utilization Review non-certified lumbar facet injections to the L3-4 and L5-S1 levels with anesthesia as an outpatient. According to the Utilization Review physician, as there was no indication of tenderness over the facets, there was not sufficient documentation or rationale for the request. Official Disability Guidelines, Low Back Chapter was referenced. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Facet Injections to the L3-4 and L5-S1 Levels with Anesthesia as an Outpatient: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Low back Chapter, Criteria for Use of Diagnostic Blocks for Facet "medicated" Pain.

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. 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. No more than 2 joint levels may be blocked at any one time. Therefore, the request for 1 Fluoroscopically guided diagnostic bilateral L3-4, L4-5, L5-S1 facet joint medial branch blocks is not medically necessary.