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| Case Number: | CM15-0033967 | | |
| Date Assigned: | 02/27/2015 | Date of Injury: | 09/21/1986 |
| Decision Date: | 04/07/2015 | UR Denial Date: | 02/09/2015 |
| Priority: | Standard | Application Received: | 02/23/2015 |

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: California

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 63 year old female, who sustained an industrial injury on 09/21/1986. The diagnoses have included lumbar degenerative disc disease, lumbar facet arthropathy, and post-laminectomy syndrome. Noted treatments to date have included chiropractic treatment, physical therapy, sacroiliac joint injection, and medications. Diagnostics to date have included lumbar spine MRI in January 2015 which showed L5-S1 facet arthropathy and L1-2 disc protrusion and neural foraminal narrowing and an electromyography in August 2014 showed S1 bilateral radiculopathy per progress note dated 02/23/2015. In a progress note dated 01/28/2015, the injured worker presented with complaints of worsening low back pain with associated bilateral hip pain and anterior thigh tenderness. The treating physician reported significant pain relief with left sacroiliac joint injection. Utilization Review determination on 02/09/2015 non-certified the request for Bilateral L5-S1 Facet Injections to the Lumbar Spine citing Medical Treatment Utilization Schedule American College of Occupational and Environmental Medicine Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L5-S1 Facet Injections to the Lumbar Spine: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Lumbar & Thoracic/Acute & Chronic Section: Facet Joint Diagnostic Blocks/Injections Section: Facet Syndrome/Diagnosis.

Decision rationale: The Official Disability Guidelines comment on the use of Facet Injections to the Lumbar Spine. These guidelines state the following: 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. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. In this case it is unclear whether the patient meets these above cited criteria for facet injections for the lumbar spine. The records suggest that the patient has a component of radicular pain. Facet injections are not intended as a treatment for radicular pain. It is also unclear whether the patient's underlying symptoms are due to facet syndrome. The Official Disability Guidelines provide guidance as to the diagnostic criteria for lumbar facet syndrome. They state the following: Recommend diagnostic criteria below. It is recommended that a thorough patient history be obtained to exclude alternative etiologies of pain (particularly radiculopathies). The most commonly involved lumbar joints are L4-5 and L5-S1. In the lumbar region, the majority of patients have involvement in no more than two levels. Physical exam findings & symptoms: As most examinations simultaneously test several structures including muscles, ligaments, discs and facets, there is no suggested physical maneuver or tests to effectively diagnose facet joint mediated pain. Axial low back pain is generally present with lumbar paravertebral tenderness. There is no reliable pain referral pattern other than that pain is 'pseudoradicular.' It is suggested that pain from upper facet joints tends to extend to the flank, hip and upper lateral thighs, while the lower joint mediated pain tends to penetrate deeper into the thigh (generally lateral and posterior). Infrequently, pain may radiate into the lateral leg or even more rarely into the foot, although multiple references indicate pain distal to the knee is rarely associated with facet joint pathology. In the presence of osteophytes, synovial cysts (diagnosed with MRI) or facet hypertrophy (diagnosed on imaging), radiculopathy may also be present. In patients with these

latter conditions, injection therapy will generally not alleviate pain that originates primarily from the anterior or posterior ligaments or bone. In 1998, Revel et al. suggested that the presence of the following were helpful in identifying patients with this condition: (1) age > 65; (2) pain relieved when supine; (3) no increase in pain with coughing, hyperextension, forward flexion, rising from flexion or extension/rotation. Radiographic findings: There is no support in the literature for the routine use of imaging studies to diagnose lumbar facet mediated pain. Studies have been conflicting in regards to CT and/or MRI evidence of lumbar facet disease and response to diagnostic blocks or neurotomy. Degenerative changes in facets identified by CT do not correlate with pain and are part of the natural degenerative process. Differential diagnosis: Other causes of predominately axial low back pain must be considered in the differential diagnosis including discogenic pain, sacroiliac joint pathology, ligamentous injury, and myofascial pain. Within the context of facet pathology, inflammatory arthritis should be considered as a differential diagnosis. Conditions include rheumatoid arthritis, ankylosing spondylitis, gout, psoriatic arthritis, reactive arthritis (and other spondyloarthropathies) as well as osteoarthritis and synovitis. Suggested indicators of pain related to facet joint pathology (acknowledging the contradictory findings in current research): (1) Tenderness to palpation in the paravertebral areas (over the facet region); (2) Predominate axial low back pain; (3) Absence of radicular findings in a dermatomal distribution, although pain may radiate below the knee. In this case, there is insufficient documentation that the patient has met the above cited criteria for facet syndrome. For the above stated reasons, bilateral L5-S1 facet injections to the lumbar spine are not considered as medically necessary.