

<b>Case Number:</b>	CM15-0085060		
<b>Date Assigned:</b>	05/07/2015	<b>Date of Injury:</b>	09/21/2000
<b>Decision Date:</b>	06/15/2015	<b>UR Denial Date:</b>	04/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/04/2015

### 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: Internal 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 injured worker is a 69 year old male, who sustained an industrial injury on 9/21/2000. The mechanism of injury was not noted. The injured worker was diagnosed as having low back pain. Treatment to date has included diagnostics, lumbar spinal surgery in 2009, chiropractic, and medications. Magnetic resonance imaging of the lumbar spine (6/11/2012 and 3/06/2015) were submitted. X-ray of the lumbar spine (12/03/2014) was submitted. Currently, the injured worker complains of returning pain in the past year. He reported low back pain, throwing his gait off, with increased leg and hip pain, due to abnormal gait. He recently developed intermittent pain to the bottom of his feet. Current medication use included Vicodin, Arthrotec, and Soma. Physical exam noted an antalgic gait and difficulty with heel to toe walking. Suboccipital tenderness was noted and deep tendon reflexes were 2+. Pain rating and functional status was not documented. Options were discussed and he desired conservative therapy. The treatment plan included a referral for bilateral L3-4 and L4-5 facet injections.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Facet Injections at Bilateral L3-L4 with fluoroscopy (lumbar spine), Qty 2: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301, 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Facet joint intra-articular injections (therapeutic blocks), Facet joint medial branch blocks (therapeutic injections), Facet joint chemical rhizotomy, Facet joint radiofrequency neurotomy, Facet rhizotomy (radio frequency medial branch neurotomy). ACOEM 3rd Edition Low back disorders 2011 <http://www.guideline.gov/content.aspx?id=38438>.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses facet joint injections for low back conditions. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (page 300) indicates that invasive techniques (e.g., local injections and facet joint injections of cortisone and lidocaine) are of questionable merit. Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (page 309) indicates that facet joint injections are not recommended. Official Disability Guidelines (ODG) state that regarding facet joint radiofrequency neurotomy, facet rhizotomy, radiofrequency medial branch neurotomy, radiofrequency ablation (RFA), studies have not demonstrated improved function with these procedures. Official Disability Guidelines (ODG) indicate that regarding facet joint intra-articular injections for low back disorders, no more than 2 joint levels may be blocked at any one time. Per ODG, facet joint medial branch blocks (therapeutic injections) are not recommended except as a diagnostic tool. Minimal evidence for treatment. Official Disability Guidelines (ODG) indicates that facet joint chemical rhizotomy is not recommended. There are no studies. The procedure is considered experimental. Official Disability Guidelines (ODG) indicates that facet joint radiofrequency neurotomy is under study. Conflicting evidence is available as to the efficacy of this procedure. Studies have not demonstrated improved function. Facet joint radiofrequency neurotomy is also called facet rhizotomy, radiofrequency medial branch neurotomy, or radiofrequency ablation (RFA). ACOEM 3rd Edition (2011) indicates that radiofrequency neurotomy and facet rhizotomy are not recommended. ACOEM 3rd Edition (2011) indicates that radiofrequency neurotomy, neurotomy, and facet rhizotomy is not recommended. ACOEM 3rd Edition (2011) indicates that diagnostic facet joint injections and therapeutic facet joint injections are not recommended for low back disorders. Lumbar MRI magnetic resonance imaging 3/6/15 revealed transitional anatomy. The cystic mass at the left L3-4 foramen is been removed. Enhancing scar is seen in the left L3-L4 foramen. A hemangioma is seen in the L5 vertebral body. There are pseudoarthrosis bilaterally at L5-S1, and facet arthropathy L3-4 through L4-5. No central stenosis. At L2-L3, no significant disc herniation, or nerve root impingement. No foraminal or canal stenosis. At L3-L4, a cystic mass in the left foramen has been removed. Enhancing scar is seen in the left foramen. Moderate facet arthropathy la noted. No central stenosis. At L4-L5, there is 3 mm of bulging with borderline foraminal narrowing on the right aide. Moderate facet arthropathy is seen. No central stenosis. At L5-S1, transitional anatomy is evident. Pseudoarthrosis are seen bilaterally. No central disc protrusion or foraminal narrowing. The facets are diminutive. The neurosurgery report dated 4/8/15 documented L3-4 hemilaminectomy with resection of synovial cyst in 2009. Physical

examination noted that the gait was normal. No lumbar spine physical examination was documented. The treatment plan included a referral for bilateral L3-4 and L4-5 facet injections. Without a documented lumbar spine physical examination, the request for lumbar facet injections is not supported. MTUS, ACOEM, and ODG guidelines do not support the request for facet injections at bilateral L3-4. Therefore, the request for facet injections at bilateral L3-4 is not medically necessary.

**Facet Injections at Bilateral L4-L5 with fluoroscopy (lumbar spine), Qty 2: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301, 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Facet joint intra-articular injections (therapeutic blocks), Facet joint medial branch blocks (therapeutic injections), Facet joint chemical rhizotomy, Facet joint radiofrequency neurotomy, Facet rhizotomy (radio frequency medial branch neurotomy). ACOEM 3rd Edition Low back disorders 2011 <http://www.guideline.gov/content.aspx?id=38438>.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses facet joint injections for low back conditions. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (page 300) indicates that invasive techniques (e.g., local injections and facet joint injections of cortisone and lidocaine) are of questionable merit. Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (page 309) indicates that facet joint injections are not recommended. Official Disability Guidelines (ODG) state that regarding facet joint radiofrequency neurotomy, facet rhizotomy, radiofrequency medial branch neurotomy, radiofrequency ablation (RFA), studies have not demonstrated improved function with these procedures. Official Disability Guidelines (ODG) indicate that regarding facet joint intra-articular injections for low back disorders, no more than 2 joint levels may be blocked at any one time. Per ODG, facet joint medial branch blocks (therapeutic injections) are not recommended except as a diagnostic tool. Minimal evidence for treatment. Official Disability Guidelines (ODG) indicates that facet joint chemical rhizotomy is not recommended. There are no studies. The procedure is considered experimental. Official Disability Guidelines (ODG) indicates that facet joint radiofrequency neurotomy is under study. Conflicting evidence is available as to the efficacy of this procedure. Studies have not demonstrated improved function. Facet joint radiofrequency neurotomy is also called facet rhizotomy, radiofrequency medial branch neurotomy, or radiofrequency ablation (RFA). ACOEM 3rd Edition (2011) indicates that radiofrequency neurotomy and facet rhizotomy are not recommended. ACOEM 3rd Edition (2011) indicates that radiofrequency neurotomy, neurotomy, and facet rhizotomy is not recommended. ACOEM 3rd Edition (2011) indicates that diagnostic facet joint injections and therapeutic facet joint injections are not recommended for low back disorders. Lumbar MRI magnetic resonance imaging 3/6/15 revealed transitional anatomy. The cystic mass at the left L3-4 foramen is been removed. Enhancing scar is seen in the left L3-L4 foramen. A

hemangioma is seen in the L5 vertebral body. There are pseudoarthrosis bilaterally at L5-S1, and facet arthropathy L3-4 through L4-5. No central stenosis. At L2-L3, no significant disc herniation, or nerve root impingement. No foraminal or canal stenosis. At L3-L4, a cystic mass in the left foramen has been removed. Enhancing scar is seen in the left foramen. Moderate facet arthropathy is noted. No central stenosis. At L4-L5, there is 3 mm of bulging with borderline foraminal narrowing on the right side. Moderate facet arthropathy is seen. No central stenosis. At L5-S1, transitional anatomy is evident. Pseudoarthrosis are seen bilaterally. No central disc protrusion or foraminal narrowing. The facets are diminutive. The neurosurgery report dated 4/8/15 documented L3-4 hemilaminectomy with resection of synovial cyst in 2009. Physical examination noted that the gait was normal. No lumbar spine physical examination was documented. The treatment plan included a referral for bilateral L3-4 and L4-5 facet injections. Without a documented lumbar spine physical examination, the request for lumbar facet injections is not supported. MTUS, ACOEM, and ODG guidelines do not support the request for facet injections at bilateral L4-5. Therefore, the request for facet injections at bilateral L4-5 is not medically necessary.