

<b>Case Number:</b>	CM14-0196720		
<b>Date Assigned:</b>	12/04/2014	<b>Date of Injury:</b>	12/04/2007
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	11/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/24/2014

### 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. The expert reviewer is Board Certified in Neurology, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in New Jersey. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 64-year-old man who sustained a work related injury on December 4, 2007. Subsequently, he developed chronic low back pain. MRI of the lumbar spine dated April 12, 2011 showed straightening of lumbar lordosis. There was degenerative disc disease noted at L2-3, L3-4, and L4-5 levels. There was minimal Schmorl's node visualized at L2-3 level. There was modic type II end plate changes noted at T12-L1 level. There was annular tear noted at L5-S1 level, anteriorly. At L4-5, there was diffuse disc protrusion with osteophyte complex that effaced the thecal sac. There was mild narrowing of the bilateral lateral recesses with effacement of the left and right L5 transiting nerve roots. There was moderate bilateral facet joint hypertrophy. There was bilateral neuroforaminal stenosis and there was facet hypertrophy and diffused disc material that effaces the L4 exiting nerve roots bilaterally. The x-rays of the lumbosacral spine reviewed on February 19, 2014 showed moderate lateral osteophytes particularly at L3-4 and there was sclerosis of the facet joints inferiorly at L4-5 and L5-S1. On the lateral view, there was loss of the normal lordotic curvature. There was loss of disc space height particularly at L5-S1 and to a lesser L4-5. According to a follow-up report dated October 15, 2014, the patient reported increased pain in his lower back, which remained mostly axial in nature. He denied of any radicular symptoms in his lower extremity and rated his pain at 8/10. The patient pain was facet generated, having gone 2 successful facet joint injections, which provided extended pain relief. He underwent facet joint injection on April 20, 2014, which provided 70% relief, which lasted 5 months of benefit. His prior facet joint injection on April 2, 2008 provided 10 months of relief. The patient has been experiencing increased pain in his neck with associated cervicogenic headaches with radicular symptoms to the upper extremity. Examination of the lumbar spine revealed tenderness to palpation bilaterally, with increased muscle rigidity. There were numerous trigger points palpable and tender throughout the lumbar paraspinal muscles. There was noted

muscle guarding with range of motion. Pain was reproducible with facet loading noted on the lower lumbar spine. Sensory exam with Wartenberg pinprick wheel was decreased in the posterolateral thigh and posterolateral calf more so on the right when compared to the left. There was mild decrease dorsiflexion of the right foot and ankle. The straight leg raise in the modified sitting position was positive at 65 degrees on the right. The patient was diagnosed with lumbar spine sprain/strain with lumbar facet syndrome, right achilles tendon partial tear, bilateral shoulder impingement syndrome, right greater than left, cervical sprain/strain syndrome, reactionary depression/anxiety, and medication-induced gastritis. The provider requested authorization for 6 lumbar facet joint injections bilateral L3-L4, L4-L5, L5-S1.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **6 Lumbar facet joint injections bilateral L3-L4, L4-L5, L5-S1: 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, Facet Joint Diagnostic Blocks

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines

**Decision rationale:** According to 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 facet 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. 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.<sup>5</sup> 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. The guidelines do not allow facet injection for more than 2 joint levels. In addition, there is no clear evidence or documentation that lumbar facets are main pain generator. It is unclear if the patient failed a full course of conservative care prior to this request. Therefore, the request for 6 lumbar facet joint injections bilateral L3-L4, L4-L5, L5-S1 is not medically necessary.