

<b>Case Number:</b>	CM15-0175384		
<b>Date Assigned:</b>	09/16/2015	<b>Date of Injury:</b>	07/17/2002
<b>Decision Date:</b>	10/19/2015	<b>UR Denial Date:</b>	08/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2015

### 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: North Carolina

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 56 year old male, who sustained an industrial injury on 7-17-2002. He reported injury to the low back, right shoulder and upper back pain from a fall. Diagnoses include lumbar spondylosis without myelopathy, low back pain, myofascial pain syndrome and chronic pain syndrome, status post right shoulder surgery and lumbar disc arthroplasty. Treatments to date include activity modification, medication therapy, chiropractic therapy, and therapeutic injections. Currently, he complained of increased low back pain and lumbar facet pain with standing and extending. He reported new symptoms after chiropractic therapy including numbness and tingling down both legs. Current pain was rated 9 out of 10 VAS. Medications listed included Norco. It was noted he failed over the counter NSAID therapy and a Medrol Dosepak prescribed approximately three weeks earlier. On 8-17-15, the physical examination documented positive lumbar facet loading maneuvers, difficulty transferring into and out of the chair, and decreased sensation to bilateral lower extremities. The MRI dated 9-30-14 revealed lumbar disc bulge and bilateral foraminal narrowing. The plan of care included an MRI to evaluate placement of ProDisc. The appeal requested authorization for bilateral L4-L5 and L5-S1 facet injections and a lumbar spine MRI without contrast. The Utilization Review dated 8-24-15, denied the request indicating that the medical records did not document evidence of radiculopathy to support medical necessity per the California MTUS Guidelines.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral L4-L5 and L5-S1 facet injections:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care.

**Decision rationale:** The ACOEM states: 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. Per the ODG, facet joint injections are under study. Current evidence is conflicting as to this procedure and at this time, no more than one therapeutic intra-articular block is suggested. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are currently not recommended as a treatment modality in most evidence based reviews as their benefit remains controversial. Criteria for use of diagnostic blocks for facet nerve pain: 1. One set of diagnostic medial branch blocks is required with a response of 70%. 2. Limited to non-radicular cervical pain and no more than 2 levels bilaterally. 3. Documentation of failure of conservative therapy. 4. No more than 2 joint levels are injected in 1 session. 5. Diagnostic facet blocks should be performed in patients whom a surgical procedure is anticipated. The requested service is not recommended per the ACOEM or the Official Disability Guidelines. Criteria have not been met in the provided clinical documentation as the patient does have radicular pain symptoms and no facet tenderness at selected levels. Therefore, the request is not medically necessary.

**MRI of the lumbar spine without contrast:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** The ACOEM chapter on low back complaints and special diagnostic studies states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can

discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.