

<b>Case Number:</b>	CM13-0002782		
<b>Date Assigned:</b>	12/04/2013	<b>Date of Injury:</b>	11/18/2008
<b>Decision Date:</b>	01/24/2014	<b>UR Denial Date:</b>	07/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesia has a subspecialty in Acupuncture and Pain Medicine and is licensed to practice in California. 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 physician 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:

48y/o male injured worker with date of injury 11/18/08 has related low back pain. He has been diagnosed with mechanical low back pain, failed back surgery syndrome, lumbar degenerative disc disease, left lower extremity radiculopathy, and probable lumbar facet joint arthropathy. In January 2002 the injured worker sustained a non-work related injury to his lumbar spine, subsequent lumbar MRI scan demonstrated a disc herniation and disc degeneration; and on 3/27/02 he underwent laminectomy and discectomy. Following his 2008 injury, he underwent lumbar MRI scan on 11/19/08 which demonstrated a large disc herniation at L4-L5. After evaluation by a neurosurgeon, he underwent decompressive laminectomies at L4-L5 and L5-S1, and an L4-sacrum fusion. 1/18/10 the injured worker underwent a trial spinal cord stimulator that did not provide significant pain relief. An exacerbation of LBP caused by bending over resulted in another lumbar MRI performed 2/10/11 which revealed disc protrusion at L2-L3. He was treated with ESI which did not significantly relieve pain, and was recommended for surgery. 12/12/11 surgery was performed extending the fusion to L3-L4 in conjunction with a decompression from L2 to L4; but unfortunately the surgery did not relieve the injured worker's symptoms. On 2/28/13 the applicant was in an automobile accident and sustained compression fractures of L1 and L2. Lumbar MRI scan 7/17/13 showed 4.5 mm of retropulsion of the vertebral body at L1 (70% loss of height) though no significant conus compression, as well as a 25% compression fracture at L2. The injured worker is refractory to epidural steroid injections, spinal cord stimulation, and medications including NSAIDs, opiates, and anti-epileptics. The date of UR decision was 7/2/13.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**for bilateral L4, L5, S1 medial branch nerve block:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Facet joint diagnostic blocks (Injections).

**Decision rationale:** Above citation notes, "Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks" but beyond that MTUS is silent on specific requirements for this intervention in the lumbar spine. The ODG indicates that criteria for facet joint diagnostic blocks (injections) are as follows: 1. One set of diagnostic medial branch blocks is required with a response of  $\geq 70\%$ . 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. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)] With respect to criteria number 11, the injured worker has had a previous fusion procedure at L4-sacrum (11/19/08) which was extended to L3-L4 (12/12/11). Additionally, with regard to criteria number 2, the injured worker has a history of radicular pain. Failure to meet the criteria set forth by the ODG establishes that this request is not medically necessary.