

<b>Case Number:</b>	CM13-0040224		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	06/27/2008
<b>Decision Date:</b>	02/18/2014	<b>UR Denial Date:</b>	10/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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 Pain Management, has a subspecialty in Disability Evaluation 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:

The claimant is a 56 years old male with stated date of work related injury of June 2008. According to medical record, the claimant stated that as he was sitting in his work truck while in complete stop, a motor vehicle struck him from behind. He developed low back pain and headaches. He subsequently underwent lumbar spine surgery after failing conservative treatment. he has had medications, chiropractic and extensive physical therapy. He continues to report low back pain that is 70% in his low back and axial in nature and 30% of the time will radiate into his bilateral feet. In the most recent progress report dated September 2013, the primary treating physician stated: "At this point in time the patient has failed conservative treatment and continues to have mainly axial low back pain. I saw this patient two years ago for consult and felt that he would be a great candidate for a trial of medical branch blocks to temporarily anesthetize the bilateral L4-5 and L5-S1 facet joint regions. I continue to believe that this is an excellent starting point. If he has significant relief of his axial low back pain, a radiofrequency ablation procedure could be performed to provide longer term relieve. If medial branch blocks do not provide any relief, consideration could be given for epidural steroid injection the patient does have some radicular pain complaints."

### 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 medial branch block trial:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter

**Decision rationale:** CA-MTUS (Effective July 18, 2009): According to ACOEM guidelines, page 300-301 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. There is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet presenting in the transitional phase between acute and chronic pain neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. According to the Official Disability Guidelines: Low Back Chapter Facet joint injections, lumbar See Facet joint injections, multiple series; Facet joint diagnostic blocks (injections); Facet joint intra-articular injections (therapeutic blocks); Facet joint medial branch blocks (therapeutic injections); Facet joint pain, signs & symptoms; & Facet joint radiofrequency neurotomy. Also see Neck Chapter and Pain Chapter. Diagnostic blocks: One set of medial branch blocks is recommended prior to a neurotomy. Intra-articular blocks are not recommended as the diagnostic procedure. Confirmatory blocks, while recommended for research studies, do not appear to be cost effective or to prevent the incidence of a false positive response to the neurotomy procedure itself. See Facet joint diagnostic blocks (injections). Criteria for the use of diagnostic blocks for facet "mediated" pain: 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 percent. 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 injection 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 sedat