

<b>Case Number:</b>	CM14-0005481		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	11/18/1999
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	01/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### 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 Emergency Medicine and Fellowship Trained in Emergency Medical Services and is licensed to practice in Texas. 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 injured worker is a 50-year-old male who reported an injury on 11/18/1999 due to a metal chute falling on his head. The injured worker had a history of neck pain that radiated to the bilateral shoulders and lower back radiating to the hip area. The diagnoses included cervicalgia, lumbago, lumbar facet syndrome/spondylosis, sacroiliac joint pain, and shoulder joint pain. The MRI dated 09/2013 of the lumbar spine revealed a 2 mm posterior annular disc bulge at the L3-4 and mild facet arthrosis at the L4-5 with a 2 mm posterior annular disc bulge. Mild facet arthrosis at the L5-S1 was noted. The x-ray of the lumbar spine dated 08/15/2013 revealed normal lumbar lordosis without listhesis, vertebral body heights were normal without compression fracture, and spondylotic changes in the form of marginal osteophytes at multiple levels. The injured worker's surgical procedures included a rotator cuff repair. Past treatments included medications, cervical injections, and physical therapy. The medications included oxycodone/acetaminophen 10/325 mg with a reported pain of 8/10 at best and 10/10 at worst. The physical examination of the lumbar spine dated 12/20/2013 revealed spasms to the paravertebral muscle, pain with lumbar extension and facet loading bilaterally, positive sacroiliac joint tenderness, and a negative straight leg raise. Palpation of the lower extremities was within normal limits. The treatment plan included a medial branch nerve block bilaterally. The Request for Authorization dated 01/24/2014 was submitted with documentation. The rationale for the medial branch block was indicated that the injured worker responded to the first medial branch block with pain relief and improved function.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Repeat bilateral lumbar facet joint medial branch nerve blocks at levels L3, L4 & L5:**  
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, Facet joint diagnostic blocks (injections).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** The request for repeat bilateral lumbar facet joint medial branch nerve blocks at levels L3, L4, and L5 is not medically necessary. The California ACOEM Guidelines indicate that a facet neurotomy should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As ACOEM does not address medial branch diagnostic blocks, secondary guidelines were sought. Official Disability Guidelines indicate the criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings although pain may radiate below the knee, and a normal straight leg raise exam. There should be documentation of failure of conservative treatment including home exercise, physical therapy, and NSAIDS prior to the procedure for at least 4 to 6 weeks and no more than 2 facet joint levels should be injected in 1 session. Additionally, 1 set of diagnostic medial branch blocks is required with a response of 70%, and it is limited to no more than 2 levels bilaterally and they recommend no more than 1 set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). The clinical notes indicated that the injured worker has radicular pain that is from the lower back to the hip. The clinical notes also indicated that the injured worker had had a lumbar facet joint medial branch nerve block and received relief. However, no degree was given of the relief. As such, the request is not medically necessary.