

<b>Case Number:</b>	CM14-0120079		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	01/06/1964
<b>Decision Date:</b>	09/12/2014	<b>UR Denial Date:</b>	07/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2014

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Texas and Oklahoma. 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 74-year-old male who reported an injury on 01/06/1964. The mechanism of injury was a truck hit the injured worker in the head, he fell down, and the truck ran over his pelvis. The diagnoses were noted to include chronic back pain, displacement of the intervertebral discs without myelopathy, low back pain, and lumbar neuritis/radiculitis. The injured worker's prior studies included a computed tomography (CT) of the lumbar spine. The documentation of 06/18/2014 revealed the injured worker was being considered for an L3, L4, and L5 medial branch block. The documentation indicated if the injured worker had more than 80% improvement, then a radiofrequency ablation may be a consideration. The surgical history was noncontributory. The injured worker's medications included Levoxyl 75 mcg tablets, Lipitor 20 mg tablets, Prilosec over-the-counter 40 mg 1 capsule, tamsulosin hydrochloride 0.4 mg, and Norco. The diagnosis was back pain radiating into the bilateral legs. The documentation of 06/03/2014 revealed the injured worker had low back pain and a non-antalgic gait. The lumbar facets were painful to palpation. There was mild restriction in flexion and rotation range of motion. The injured worker had a normal sensory examination. The injured worker had normal strength. The injured worker had a positive facet loading examination. The diagnosis was other symptoms referable to back. The treatment plan included an L3, L4, and L5 bilateral medial branch block with fluoroscopic imaging and a movement onto an ablation if the injured worker received 80% relief or better from the diagnostic trial. There was no DWC form RFA submitted for the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Bilateral Medial Branch Block Trial L3, L4 and L5 times 2: 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 (Medial Branch Blocks).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** The ACOEM Guidelines indicate that a facet neurotomy (Rhizotomy) should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As ACOEM does not address specific criteria for medial branch diagnostic blocks, secondary guidelines were sought. The 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 non-steroidal anti-inflammatory drugs (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, one 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 one 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 documentation submitted for review indicated the injured worker had tenderness to palpation at the paravertebral area, a sensory examination in the absence of radicular findings. However, there was a lack of documentation of a normal straight leg examination. Additionally, there was a lack of documentation indicating a failure of conservative treatment including physical therapy and NSAIDs. The injection is limited to no more than 2 levels bilaterally and the request as submitted failed to indicate a necessity for 2 injections. There could not be the performance of 2 injections without a documentation of objective response to the first injection. Given the above, the request for a bilateral medial branch block trial L3, L4, and L5 x 2 is not medically necessary.