

<b>Case Number:</b>	CM14-0170314		
<b>Date Assigned:</b>	10/20/2014	<b>Date of Injury:</b>	02/22/2013
<b>Decision Date:</b>	12/03/2014	<b>UR Denial Date:</b>	10/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2014

### 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 Family Medicine and is licensed to practice in New Jersey. 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 worker is a 53 year old male who was injured on 2/22/2013 after lifting a heavy object. He was diagnosed with low back pain, lumbar spondylosis, lumbar degenerative disc disease, and lumbar sprain/strain. He was treated with physical therapy, acupuncture, medications, and epidural injections. On 8/21/14, the worker was seen by his pain management physician for an initial consultation reporting low back pain which radiated to both legs down to feet and associated with numbness and tingling in legs rated at 7/10 on the pain scale. He also reported having bilateral shoulder pain rated 10/10 on the pain scale. Physical examination revealed a weight of 338 lbs., tenderness of lumbar area (facet joints, midline, paraspinal muscles), normal leg muscle strength and deep tendon reflexes, decreased sensation of L4, L5, and S1 dermatomes, and decreased flexion of the lumbar spine. He was recommended bilateral L3-L4, L4-L5, and L5-S1 diagnostic medial branch blocks for the purpose of identifying if he would be a good candidate for radiofrequency ablation. He was also recommended a muscle relaxant, an NSAID, an analgesic cream, and a motorized cold therapy unit for purchase.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral L3-L4, L4-L5, and L5-S1 Medial Branch Block:** 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 - Lumbar and Thoracic (Acute and Chronic), Facet joint blocks

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back section, facet joint pain/injections

**Decision rationale:** The MTUS Guidelines do not address facet joint injections. The ODG suggests that for a diagnosis of facet joint pain, tenderness over the facet joints, a normal sensory examination, absence of radicular findings (although pain may radiate below the knee), and normal straight leg raising exam are all requirements of the diagnosis. If evidence of hypertrophy encroaching on the neural foramen is present then only two out of the four requirements above may allow for an accurate diagnosis of facet joint pain. The ODG also discusses the criteria that should be used in order to justify a diagnostic facet joint injection for facet joint disease and pain, including 1. One set of diagnostic medial branch blocks with a response of greater or equal to 70% and lasting for at least 2 hours (lidocaine), 2. Limited to patients with low back pain that is non-radicular and at no more than two levels bilaterally, 3. Documentation of failure of conservative treatments for at least 4-6 weeks prior, 4. No more than 2 facet joints injected in one session, 5. Recommended volume of no more than 0.5 cc per joint, 6. No pain medication from home should be taken at least 4 hours prior to diagnostic block and for 4-6 hours afterwards, 7. Opioids should not be given as a sedative during procedure, 8. IV sedation is discouraged, and only for extremely anxious patients, 9. Pain relief should be documented before and after a diagnostic block, 10. Diagnostic blocks are not to be done on patients who are to get a surgical procedure, and 11. Diagnostic blocks should not be performed in patients that had a fusion at the level of the planned injection. In the case of this worker, findings suggestive of radiculopathy were present. Also, more than 2 sets diagnostic blocks were requested (3). Therefore, the medial branch blocks are not medically necessary unless there is a fulfillment of all the criteria set by the MTUS.

**Motorized Cold Therapy Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous-flow cryotherapy

**Decision rationale:** The MTUS Chronic Pain Guidelines do not address specifically a water circulating cold/heat pad with pump, however they do state that at home local applications of cold in the first few days of acute injury is recommended and thereafter applications of cold or heat may be additionally helpful, particularly during acute exacerbations. The ODG also states that continuous-flow cryotherapy is recommended as an option only after surgery up to 7 days, but not for nonsurgical treatment. In the case of this worker, the procedure requested was for a diagnostic block, not a surgical procedure. Also, purchasing a unit for only a few days of treatment seems excessive considering cold therapy can be administered in much less complicated ways. Therefore, the motorized cold therapy unit for purchase is not medically necessary.

