

<b>Case Number:</b>	CM14-0176924		
<b>Date Assigned:</b>	10/30/2014	<b>Date of Injury:</b>	03/26/2007
<b>Decision Date:</b>	12/05/2014	<b>UR Denial Date:</b>	10/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/24/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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 patient is a 54-year-old male presenting with work-related injury on March 25, 2007. On September 24, 2014 the patient complained of ongoing low back pain with radicular symptoms into both legs including pain, burning and numbness and tingling. Lumbar MRI on September 19, 2014 revealed L5 - S1 disc degeneration with circumferential 3 mm disc bulge/osteophyte and mild facet arthropathy causing moderate bilateral foraminal stenosis greater on the right perineural fat is partially effaced; L4 - 5 mild disc degeneration with circumferential 2 to 3 mm disc bulge/osteophyte and slight left paracentral protrusion causing moderate stenosis of the left lateral recess; L1 - L2 right paracentral 2 mm disc protrusion mildly narrowing the left lateral recess; and mild T12 minimal L1 anterior wedge compression deformity and no acute fracture identified. The physical exam was significant for generalized tenderness and spasm in the lumbosacral spine, limited range of motion secondary to pain and approximately 70% of normal in all directions, evidence of bilateral L5-S1 radiculopathy, increased pain with extension and rotation of facet joints. The patient was diagnosed with lumbar disc herniation, lumbar spine degenerative, low back pain, sciatica, and lumbar radiculopathy L4-S1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Facet Block at levels L3-S1 with Fluoroscopy for lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter

**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 Complaints, Treatment Consideration

**Decision rationale:** Bilateral Facet Block at levels L3-S1 with Fluoroscopy for lumbar spine is not medically necessary. The Occupation medicine practice guidelines criteria for use of diagnostic facet blocks require: that the clinical presentation be consistent with facet pain; Treatment is also limited to patients with back pain that is nonradicular and had no more than 2 levels bilaterally; documentation of failed conservative therapy including home exercise physical therapy and NSAID is required at least 4-6 weeks prior to the diagnostic facet block; no more than 2 facet joint levels are injected at one session; recommended by them of no more than 0.5 cc of injectate was given to each joint; no pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4-6 hours afterward; opioid should not be given as a sedative during the procedure; the use of IV sedation (including other agents such as modafinil) may be clouded indicate the result of the diagnostic block, and should only be given in cases of extreme anxiety; the patient should document pain relief with the management such as 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 level to support subjective reports of better pain control; diagnostic blocks should not be performed in patients in whom a surgical procedures anticipated; diagnostic facet block should not be performed patients who have had a previous fusion procedure at the plan injection level. The physical exam was significant for L5-S1 radiculopathy. The guidelines state that facet injections are not recommended if the pain is radicular. Additionally, there is lack of documentation that the patient had failed an adequate trial of conservative therapy including NSAIDs and 6 weeks of physical therapy; therefore the service is not medically necessary.