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| <b>Case Number:</b>   | CM14-0067598 |                              |            |
| <b>Date Assigned:</b> | 07/11/2014   | <b>Date of Injury:</b>       | 09/29/1994 |
| <b>Decision Date:</b> | 08/11/2014   | <b>UR Denial Date:</b>       | 05/02/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/12/2014 |

### 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 Orthopedic Spine Surgery 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 injury on 09/29/1994. The diagnoses included; intervertebral disc disorders, displacement of thoracic or lumbar intervertebral disc without myelopathy. The documentation indicated the injured worker underwent surgical intervention for his knee and physical therapy. Prior treatments for the lumbar spine were not provided. The mechanism of injury was not provided. The documentation of 04/09/2014 revealed the injured worker had a diagnoses of chronic low back pain with herniated nucleus pulposus with torn disc and status post right knee multiple surgeries. The treatment recommendation was acupuncture on the previous visit and to continue with current medications. The current complaints included; the injured worker was not able to sleep through the night due to continued pain. The physical examination revealed the injured worker had decreased range of motion secondary to pain and pain with extension. Straight leg raise was slightly positive on the left. The motor function test revealed 4+/5 strength in the right extensor hallucis. There was pain in the radicular distribution consistent with S1 nerve root. The reflexes were 1/2 in the bilateral Achilles. The treatment plan included a bilateral L4 and L5 and L5-S1 facet and medial branch block.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral L4-5 amd L5-S1 facet/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 - Facet/Medial Branch Block Low back Procedure Summary (last updated 03/31/2014).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309, Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG) Low Back Chapter, Medial Branch Block.

**Decision rationale:** The 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. 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 did not have a normal sensory examination and straight leg raise. The clinical documentation indicated the injured worker had decreased reflexes and had pain in the radicular distribution consistent with the S1 nerve root as well as decreased strength in the right extensor hallucis and a positive straight leg raise. Additionally, there was lack of documentation indicating if the injured worker had a positive response to the injection that a neurotomy was chosen for treatment. Given the above, the request for bilateral L4-L5 and L5-S1 facet/medial branch block is not medically necessary.