

<b>Case Number:</b>	CM14-0187077		
<b>Date Assigned:</b>	11/17/2014	<b>Date of Injury:</b>	05/09/1997
<b>Decision Date:</b>	01/07/2015	<b>UR Denial Date:</b>	10/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2014

### 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 Neurology, has a subspecialty in Neuromuscular 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 patient is a 61-year-old woman who sustained a work-related injury on May 9, 1997. Subsequently, the patient developed chronic low back pain. According to a progress report dated October 9, 2014, the patient complained of chronic lumbar back and right hip pain. She has had successful epidural injections and has done well with chiropractic and physical therapy, but couldn't tolerate acupuncture. Since her past visit, the patient reported a minimal increase in her low back pain intensity. The patient stated that she received authorization for the lumbar MBB, though by the time she received the notification for the scheduling for the MBB, the authorization had expired. The patient rated her pain as a 10/10 without medications and 3/10 with medications. On examination, deep tendon reflexes in the upper and lower extremities were decreased but equal. There was exquisite tenderness over L3-S1 with extension and lateral bend highly suggestive of facet arthropathy. Range of motion was limited by pain. Sitting straight leg raise was negative bilaterally. There was spasm at L4-S1 paraspinal. There was decreased strength bilateral lower extremities. Deep tendon reflexes in the upper and lower extremities were decreased but equal. Sensation was decreased in left L4, right L4, right L5 and right S1. The patient was diagnosed with lumbar disc displacement without myelopathy, lumbar spine degenerative disc disease, and lumbar facet arthropathy. The provider requested authorization for lumbar MBB.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar Medial Branch Block:** 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): 309.

**Decision rationale:** According MTUS guidelines, <Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain>. According to ODG guidelines regarding facets injections, < Under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti , 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial.> Furthermore and according to ODG guidelines, < Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: 1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time. 5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. The ODG guidelines did not support facet injection for lumbar pain in this clinical context. There is no documentation of facet mediated pain or that facets are the main pain generator. There is no documentation of failure of conservative therapies in this patient. Therefore, the request for Lumbar MBB is not medically necessary.