

<b>Case Number:</b>	CM14-0196679		
<b>Date Assigned:</b>	12/04/2014	<b>Date of Injury:</b>	10/11/2004
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	11/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/24/2014

### 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 52 year old male presenting with a work related injury on 10/11/2004. The patient is status post decompression/laminectomy L4-5, L5-S1 bilateral on 08/11/2005 and right total hip arthroplasty on 12/16/2011. The patient was diagnosed with lumbar spondylosis; and post-laminectomy syndrome. The patient had medial branch blocks at L3, L4, and L5 on 07/15/2014 and 07/22/2014 as well as lumbar medial branch radiofrequency neurotomy at right L3, L4 and L5. The patient reported that the procedure was beneficial. The patient then had right sacroiliac joint injection completed on 10/15/2014. The medications included Tylenol with codeine #4, Prilosec, Naproxen, and Skelaxin. CT scan on 08/21/2014 revealed right hip arthroplasty, minor asymmetry of the polyethylene space with superior measurement 4.4 mm and inferior 4.8 mm raising the possibility of minor polyethylene wear, normal acetabular angle of abduction, three degrees of acetabular retroversion, right sacroiliac joint degenerative changes. On 10/15/2014 the patient complained of low back pain, left lower extremity pain and left hip pain. The pain is associated with tingling and numbness. A claim was made for medical branch blocks, bilateral L3-5

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Medial Branch Blocks, bilateral L3-5:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 5th Edition, 2007, Low Back

**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 Considerations

**Decision rationale:** Medial Branch blocks bilateral L3-5 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 cervical 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 interfere with 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 surgical procedures anticipated; diagnostic facet block should not be performed in patients who have had a previous fusion procedure at the plan injection level. The physical exam does not clearly indicate facet pain. The patient seems to be experiencing lumbar radiculitis with radiating pain to the left leg. Additionally, the patient had prior medial branch blocks and facet radiofrequency without documented quantifiable response of at least 70% reduction in pain for 6 months or more; therefore the requested procedure is not medically necessary.