

<b>Case Number:</b>	CM14-0198612		
<b>Date Assigned:</b>	01/06/2015	<b>Date of Injury:</b>	11/18/2013
<b>Decision Date:</b>	02/06/2015	<b>UR Denial Date:</b>	11/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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 Clinical Neurophysiology and is licensed to practice in Virginia. 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:

According to the records available for review, the injured worker is a 43-year-old male with a date of injury of 18 November, 2013. The mechanism of injury is not clarified in the records. There is a clinical note documented on 9 December, 2014. At this time the injured worker complained of low back pain which is constant. The pain radiates down the left lower extremity. The pain is accompanied by constant numbness of the left lower extremity to the level of the calf, the foot, and to the level of the toes. There is constant tingling in the left lower extremity to the level of the hip, thigh, foot and toes. There is documented muscle weakness in the left lower extremity which is intermittent. The patient describes pain that is aching, burning, dull, sharp, stabbing, throbbing, and is moderate to severe in intensity. The pain is aggravated by bending, sitting, prolonged sitting, standing, turning, twisting, and walking. There is presence of bowel dysfunction. The patient complains of frequent muscle spasms. The pain is rated as a 10 out of 10 in intensity without medications. The pain is reported as being worse since the last medical visit. The pain is improved with bed rest. The clinical exam documented on this date notes that the patient's gait was normal. Inspection of the lumbar spine reveals no gross abnormality. There is tenderness to palpation in the spinal vertebral area in the L4-S1 levels. Range of motion is moderately limited secondary to pain. Pain is increased with both flexion and extension. Sensory exam shows decrease sensation to touch in the left lower extremity. Motor exam is within normal limits in bilateral lower extremities. Straight leg raise is negative bilaterally at 90. There is an MRI-L spine documented in the record dated 5 April, 2014. On this exam there is an annular tear with a 3 mm right foraminal disc protrusion at the L5-S1 levels which together with mild facet arthropathy, results in mild right neural foraminal narrowing. There is a 6 mm anterior disc protrusion at the L2-L3 level. There is a 5 mm anterior disc protrusion at the L1-L2 level. There is mild bilateral facet arthropathy at L4-L5 and L5-S1. There is disc desiccation at

L2-L3 and L4-L5 and at L5-S1 with mild disc height loss at the L2-L3 levels. There is an EMG/NCS documented in the medical record dated 14 August, 2014. This study documents findings of acute denervation of the left lower paraspinal musculature, also with denervation of the left medial gastrocnemius muscle and the left hamstring muscle. These findings are consistent with the diagnosis of an L5 versus S1 radiculopathy on the left. There was no electrodiagnostic evidence of a lower extremity peripheral neuropathy based on this testing.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Lumbar Medial Branch Nerve Blocks at bilateral level L4-5: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 16th edition Low Back Pain, Facet-Joint Pain

**Decision rationale:** ACOEM guidelines states that "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 benefits nor does it reduce the need for surgery. ODG guidelines states that the use of diagnostic blocks for facet mediated pain is limited to patient's with low back pain that is nonradicular and consists of no more than 2 levels bilaterally. According to the medical records submitted for review, the injured worker complains of significant back and leg pain. EMG suggests that this pain is due to a lumbar radiculopathy at the L5 and S1 levels. This suggests that the injured workers pain is attributable to a radicular source. Therefore, in the case of this injured worker, lumbar median branch blocks at the L4-L5 levels are not recommended by both the MTUS and the ODG guidelines and are therefore not medically necessary.

#### **Lumbar Medial Branch Blocks at bilateral level L5-S1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 16th edition, Low Back Pain, Facet-Joint pain

**Decision rationale:** ACOEM guidelines states that "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 benefits nor does it reduce the need for surgery. ODG guidelines states that the use of diagnostic blocks for facet mediated pain is limited to patient's with low back pain that is nonradicular and consists of no more than 2 levels bilaterally. According to the medical records submitted for review, the injured worker complains of significant back and leg pain. EMG suggests that this pain is due to a lumbar radiculopathy at the L5 and S1 levels. This suggests that the injured workers pain is attributable to a radicular source. Therefore, in the case of this injured worker, lumbar median branch blocks at the L5-S1 levels are not recommended by both the MTUS and the ODG guidelines and are therefore not medically necessary.