

<b>Case Number:</b>	CM14-0202529		
<b>Date Assigned:</b>	12/15/2014	<b>Date of Injury:</b>	01/01/2012
<b>Decision Date:</b>	02/04/2015	<b>UR Denial Date:</b>	11/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2014

### 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 37-year-old woman who sustained a work related injury on January 1, 2012. Subsequently, she developed chronic low back pain. Prior conservative treatments has been extensive to include medications, physical therapy, lumbar brace, and a multi-disciplinary functional restoration program completed in June of 2014. It was noted that there was noncompliance with the program. MRI of the lumbar spine dated October 25, 2014 showed minimal degenerative changes in the lumbar spine without evidence of canal or foraminal stenosis. According to a follow-up report dated November 6, 2014, the patient stated that her pain was 7/10 in severity and constant in terms of timing. She felt that the pain does radiate to her legs with associated symptoms of tingling and weakness but no numbness. Examination of the lumbar spine revealed paravertebral tenderness to palpation adjacent to the lumbar facet joints as well as paraspinal musculature. Facet loading maneuvers bilaterally were provocative of concordant baseline pain distally. There was tenderness to palpation over the greater trochanteric bursa bilaterally. examination of the lower extremities revealed no tenderness to palpation on the lumbosacral region. No tenderness to palaption along the SI joint greater trochanter. Range of motion was normal with flexion and extension and lateral rotation. She had normal tone with no paraspinal muscle spasms. The patient's diagnoses included lumbar facet syndrome and greater trochanteric bursitis bilaterally. The provider requested authorization for Bilateral L4-5 and L5-S1 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 and L5-S1 Medial Branch Block: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**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. 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. In this case, there is no documentation of facet mediated pain; there is no clear evidence or documentation that lumbar and sacral facets are main pain generator. There is no clear documentation that the patient failed conservative therapies. Therefore, the Bilateral L4-5 and L5-S1 medial branch block is not medically necessary.