

<b>Case Number:</b>	CM14-0209959		
<b>Date Assigned:</b>	12/22/2014	<b>Date of Injury:</b>	07/08/2012
<b>Decision Date:</b>	02/25/2015	<b>UR Denial Date:</b>	12/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

50y/o male injured worker with date of injury 7/8/12 with related lumbar back pain. Per progress report dated 11/14/14, the injured worker complained of low back pain that radiated down his lower extremity. Per physical exam, there was tenderness to palpation of the lumbar sacral junction, with associated muscle tension. There was also tenderness to palpation over the lumbar facet joints. Axial loading for the lumbar facets were positive for pain. Treatment to date has included physical therapy, epidural steroid injections, and medication management. MRI of the lumbar spine dated 9/6/12 revealed a small protrusion at L4-L5, an annular bulge at L5-S1 with a left paracentral protrusion, and foraminal stenosis bilaterally, mild narrowing of the left S1 lateral recess. Treatment to date has included physical therapy, epidural steroid injections, and medication management. The date of UR decision was 12/9/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Lumbar Facet Nerve Block (MBB) L4-5 and L5-S1 1st level fluoroscopic guidance IV sedation:** 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) Low Back Chapter, Facet Diagnostic Blocks

**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, Facet Joint Diagnostic Blocks (injections).

**Decision rationale:** Per the ODG guidelines, facet joint medial branch blocks are not recommended except as a diagnostic tool, citing minimal evidence for treatment. The ODG indicates that criteria for facet joint diagnostic blocks (injections) are as follows: 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a "sedative" during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a 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 logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)] The documentation submitted for review indicates that the injured worker indeed suffers from radiculopathy per imaging study and clinical findings. Furthermore, the guidelines indicate that IV sedation should not be used for this procedure. As this procedure is limited to patients with low-back pain that is non-radicular, the request is not medically necessary.