

<b>Case Number:</b>	CM15-0007090		
<b>Date Assigned:</b>	02/05/2015	<b>Date of Injury:</b>	07/19/1990
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	01/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 injured worker is a 75-year-old female, who sustained an industrial injury on July 19, 1990. The diagnoses have included carpal tunnel syndrome, cervical spondylosis without myelopathy, cervical spondylosis with myelopathy, unspecified disorders of bursae and tendons in the shoulder region, primary localized osteoarthritis lower leg, lumbosacral spondylosis, without myelopathy, localized osteoarthritis not specified whether primary or secondary hand, thoracic spondylosis without myelopathy, encounter for long term use of other medications, ulcer of lower limbs, except pressure ulcer, other specified disorders of rotator cuff syndrome of shoulder and allied disorders, osteoarthritis unspecified whether generalized or localized lower leg, and thoracic or lumbosacral neuritis or radiculitis unspecified. Treatment to date has included pain medication, physical therapy and epidural. Currently, the injured worker complains of right knee pain. In a progress note dated December 16, 2014, the treating provider reports examination of the right knee reveals abnormal gait, decreased range of motion, joint effusion, palpable tenderness to the medial joint line and lateral joint line.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) right lumbar L3, L4, L5 medial branch block, as an outpatient: 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) online version Low Back chapter; facet joint diagnostic blocks (injections).

**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. 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 were no physical exam findings listed for the lumbar region in the medical report dated December 16, 2014. In addition, the patient has had a bilateral lumbar L3, L4, and L5 medial branch blocks performed on November 24, 2014 without any documentation of the outcome of the procedure. Therefore, the request for 1 right lumbar L3, L4, L5 medial branch block is not medically necessary.