

<b>Case Number:</b>	CM15-0103284		
<b>Date Assigned:</b>	06/05/2015	<b>Date of Injury:</b>	02/07/2010
<b>Decision Date:</b>	07/10/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### CLINICAL CASE SUMMARY

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

This 64-year-old male sustained an industrial injury on 2/7/10. He subsequently reported back pain. Diagnoses include lumbar spine strain and radiculopathy, thoracic spine disc herniation, lumbago and rotator cuff tear. Treatments to date include x-ray and MRI testing, back surgery, physical therapy and prescription pain medications. The injured worker continues to experience low back pain which radiates to the lower extremities. Upon examination, there was antalgic gait noted. There was tenderness to palpation to the lumbar paraspinal muscles and sacroiliac joints. Lumbar range of motion is decreased. Straight leg raising test is positive. A request for Left lumbar facet block L3-S1, right lumbar facet block L3-S1, fluoroscopy and Physician's surgery center facility (outpatient) was made by the treating physician.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left lumbar facet block L3-S1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official disability guidelines Low Back Chapter, under Facet Joint Diagnostic Blocks.

**Decision rationale:** The patient presents on 04/27/15 with lower back pain rated 3/10, and associated numbness and tingling in the right foot. The patient's date of injury is 02/07/10. Patient is status post lumbar laminectomy at unspecified levels in 2004. The request is for LEFT LUMBAR FACET BLOCK L3-S1. The RFA is dated 04/27/15. Physical examination dated 04/27/15 reveals tenderness to palpation of the lumbar paraspinal muscles and SI joints, limited range of motion in the lumbar spine secondary to pain, and negative straight leg raise bilaterally. Neurological examination reveals decreased sensation along the L5 dermatomal distribution bilaterally. The patient's current medication regimen was not provided. Diagnostic imaging included lumbar MRI dated 11/29/13, significant findings include: "Multilevel degenerative changes within the lumbar spine, particularly at L2-3 through L5-S1, L2-3 2mm retrolisthesis and there is diffuse disc bulge measuring up to 4mm, L4-5: There is 3-4mm diffuse disc bulge/osteophyte complex asymmetric to the left paracentral/foraminal region, moderate foraminal narrowing on the left, L5-S1: There is a 4mm broad based disc bulge asymmetric to the left paracentral/foraminal region, mild-to-moderate foraminal narrowing on the left and moderate foraminal narrowing on the right. " Patient is currently working. ODG Low Back Chapter, under Facet Joint Diagnostic Blocks states: "Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment - a procedure that is still considered "under study". Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block. Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. Criteria for the use of diagnostic blocks for facet "mediated" pain: 4.) No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). " ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12 low back complaints, under "Physical Methods", pages 300 states Invasive techniques (e. g. , local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. In regard to the request for what appears to be this patient's first lumbar facet block, the provider has specified an excessive number of levels to be injected. ODG offers support for one diagnostic facet joint block prior to facet neurotomy, however the guidelines clearly indicate that no more than two facet levels are to be injected. In this case, the provider has requested an injection at 3 facet levels: L3/4, L4/5, and L5/S1, exceeding guideline recommendations. Therefore, the request IS NOT medically necessary.

**Right lumbar facet block L3-S1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official disability guidelines Low Back Chapter, under Facet Joint Diagnostic Blocks.

**Decision rationale:** The patient presents on 04/27/15 with lower back pain rated 3/10, and associated numbness and tingling in the right foot. The patient's date of injury is 02/07/10. Patient is status post lumbar laminectomy at unspecified levels in 2004. The request is for RIGHT LUMBAR FACET BLOCK L3-S1. The RFA is dated 04/27/15. Physical examination dated 04/27/15 reveals tenderness to palpation of the lumbar paraspinal muscles and SI joints, limited range of motion in the lumbar spine secondary to pain, and negative straight leg raise bilaterally. Neurological examination reveals decreased sensation along the L5 dermatomal distribution bilaterally. The patient's current medication regimen was not provided. Diagnostic imaging included lumbar MRI dated 11/29/13, significant findings include: "Multilevel degenerative changes within the lumbar spine, particularly at L2-3 through L5-S1, L2-3 2mm retrolisthesis and there is diffuse disc bulge measuring up to 4mm, L4-5: There is 3-4mm diffuse disc bulge/osteophyte complex asymmetric to the left paracentral/foraminal region, moderate foraminal narrowing on the left, L5-S1: There is a 4mm broad based disc bulge asymmetric to the left paracentral/foraminal region, mild-to-moderate foraminal narrowing on the left and moderate foraminal narrowing on the right. " Patient is currently working. ODG Low Back Chapter, under Facet Joint Diagnostic Blocks states: "Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment - a procedure that is still considered "under study". Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block. Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. Criteria for the use of diagnostic blocks for facet "mediated" pain: 4. ) No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). " ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12 low back complaints, under "Physical Methods", pages 300 states Invasive techniques (e. g. , local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. In regard to the request for what appears to be this patient's first lumbar facet block, the provider has specified an excessive number of levels to be injected. ODG offers support for one diagnostic facet joint block prior to facet neurotomy, however the guidelines clearly indicate that no more than two facet levels are to be injected. In this case, the provider has requested an injection at 3 facet levels: L3/4, L4/5, and L5/S1, exceeding guideline recommendations. Therefore, the request IS NOT medically necessary.

**Fluoroscopy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official disability guidelines Low Back Chapter, under Facet Joint Diagnostic Blocks.

**Decision rationale:** The patient presents on 04/27/15 with lower back pain rated 3/10, and associated numbness and tingling in the right foot. The patient's date of injury is 02/07/10. Patient is status post lumbar laminectomy at unspecified levels in 2004. The request is for FLUOROSCOPY. The RFA is dated 04/27/15. Physical examination dated 04/27/15 reveals tenderness to palpation of the lumbar paraspinal muscles and SI joints, limited range of motion in the lumbar spine secondary to pain, and negative straight leg raise bilaterally. Neurological examination reveals decreased sensation along the L5 dermatomal distribution bilaterally. The patient's current medication regimen was not provided. Diagnostic imaging included lumbar MRI dated 11/29/13, significant findings include: "Multilevel degenerative changes within the lumbar spine, particularly at L2-3 through L5-S1, L2-3 2mm retrolisthesis and there is diffuse disc bulge measuring up to 4mm, L4-5: There is 3-4mm diffuse disc bulge/osteophyte complex asymmetric to the left paracentral/foraminal region, moderate foraminal narrowing on the left, L5-S1: There is a 4mm broad based disc bulge asymmetric to the left paracentral/foraminal region, mild-to-moderate foraminal narrowing on the left and moderate foraminal narrowing on the right. " Patient is currently working. ODG Low Back Chapter, under Facet Joint Diagnostic Blocks states: "Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment - a procedure that is still considered "under study". Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block. Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. . . Criteria for the use of diagnostic blocks for facet "mediated" pain: 4. ) No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). " ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12 low back complaints, under "Physical Methods", pages 300 states Invasive techniques (e. g. , local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. In regard to the fluoroscopic guidance for a series of lumbar facet blocks, the paired request specifies an excessive number of levels to be injected and is not supported. Normally fluoroscopic guidance is utilized to ensure proper needle placement during the procedure, however the request as written specifies three levels to be injected (exceeding the 2 levels specified by ODG) and cannot be substantiated. Therefore, the associated fluoroscopic guidance is not required. The request IS NOT medically necessary.

**Physician's surgery center facility (outpatient):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official disability guidelines Low Back Chapter, under Facet Joint Diagnostic Blocks.

**Decision rationale:** The patient presents on 04/27/15 with lower back pain rated 3/10, and associated numbness and tingling in the right foot. The patient's date of injury is 02/07/10. Patient is status post lumbar laminectomy at unspecified levels in 2004. The request is for PHYSICIAN'S SURGERY CENTER FACILITY (OUTPATIENT). The RFA is dated 04/27/15. Physical examination dated 04/27/15 reveals tenderness to palpation of the lumbar paraspinal muscles and SI joints, limited range of motion in the lumbar spine secondary to pain, and negative straight leg raise bilaterally. Neurological examination reveals decreased sensation along the L5 dermatomal distribution bilaterally. The patient's current medication regimen was not provided. Diagnostic imaging included lumbar MRI dated 11/29/13, significant findings include: "Multilevel degenerative changes within the lumbar spine, particularly at L2-3 through L5-S1, L2-3 2mm retrolisthesis and there is diffuse disc bulge measuring up to 4mm, L4-5: There is 3- 4mm diffuse disc bulge/osteophyte complex asymmetric to the left paracentral/foraminal region, moderate foraminal narrowing on the left, L5-S1: There is a 4mm broad based disc bulge asymmetric to the left paracentral/foraminal region, mild-to-moderate foraminal narrowing on the left and moderate foraminal narrowing on the right. " Patient is currently working. ODG Low Back Chapter, under Facet Joint Diagnostic Blocks states: "Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment - a procedure that is still considered "under study". Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block. Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. Criteria for the use of diagnostic blocks for facet "mediated" pain: 4.) No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). "ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12 low back complaints, under "Physical Methods", pages 300 states Invasive techniques (e. g., local injections and facet joint injections of cortisone and lidocaine) are of questionable merit. In regard to the outpatient treatment at a surgery center for a series of lumbar facet blocks, the paired request specifies an excessive number of levels to be injected and is not supported. The request as written specifies three levels to be injected (exceeding the 2 levels specified by ODG) and cannot be substantiated. Therefore, the associated outpatient visit is not required. The request IS NOT medically necessary.