

<b>Case Number:</b>	CM15-0108787		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	03/03/2014
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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, Alabama, 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 50 year old male with an industrial injury dated 03/03/2014. The injured worker's diagnoses include lumbar/lumbosacral disc degeneration, lumbago and sacroiliitis necrosis. Treatment consisted of Magnetic Resonance Imaging (MRI) of the lumbar spine dated 4/11/2014, prescribed medications, bilateral sacroiliac (SI) injection dated 4/2/2015 and periodic follow up visits. In a progress note dated 04/22/2015, the injured worker reported back pain, greater in the left than right, radiating to the buttocks and posterior thigh. The injured worker reported that the sacroiliac (SI) injection did not work. The injured worker also reported insomnia due to pain. The injured worker rated pain a 10/10 without medication and an 8/10 with medication. Objective findings revealed tenderness to palpitation of the paraspinous and sacroiliac (SI) joint, mild spasm, tenderness in the right buttock, bilateral positive facet loading and restricted range of motion due to pain. The treating physician prescribed services for bilateral medial branch block of the lumbar spine, additional level with fluoroscopy guidance now under review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral MB Block:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 174-175, 187. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter, and Low Back Chapter.

**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 clear evidence that lumbar facets are the main pain generator. The diagnosis of radiculopathy or spinal stenosis was not fully excluded in this case. Therefore, the request for Bilateral Lumbar Medial Branch Blocks is not medically necessary.

**Additional level:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 174-175, 187. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter and Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 309.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Fluoroscopy guidance:** 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): 309.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.