

<b>Case Number:</b>	CM15-0142603		
<b>Date Assigned:</b>	08/03/2015	<b>Date of Injury:</b>	09/19/2012
<b>Decision Date:</b>	08/31/2015	<b>UR Denial Date:</b>	07/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2015

### 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: Arizona, California  
 Certification(s)/Specialty: Family Practice

### 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 41-year-old female who sustained an industrial injury on 9-19-12 with current complaints of numbness in both legs, arms and hands. In a visit note dated 7-2-15, the physician notes her legs are getting weaker and the numbness in her right hand is increasing. In an initial pain management evaluation report dated 6-12-15, the physician notes low back pain radiating down to the ankles. She complains of weakness in the lower extremity and numbness and tingling. Pain is rated at 7 out of 10. Current medication is Norco, Lyrica, Robaxin, Ambien, Omeprazole, and Naprosyn. Exam of the lumbar spine reveals guarding with range of motion and sensation is somewhat diminished in the L5 dermatome. Straight leg raise is equivocal. A nerve conduction study of the lower extremities dated 10-30-14 reveals findings suggestive of chronic right S1 and chronic left L5 radiculopathy. The impression is lumbar facet syndrome. She has failed conservative treatments such as anti-inflammatory drugs, muscle relaxers, and physical therapy. The requested treatment is bilateral L4-L5 and L5-S1 facet injections.

### 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 facet injections:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, page 300 Official Disability Guidelines, Low Back.

**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 and pg 36.

**Decision rationale:** According to the guidelines, criteria for the use of diagnostic blocks for facet 'mediated' pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 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.] In this case, the claimant does have radicular symptoms and findings on examination. Radiculopathy is exclusion for facet injections. As a result, the request for lumbar facet injection is not medically necessary.