

<b>Case Number:</b>	CM15-0194113		
<b>Date Assigned:</b>	10/07/2015	<b>Date of Injury:</b>	12/21/2012
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	09/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2015

### 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 York, Tennessee

Certification(s)/Specialty: Emergency 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 40 year old male, who sustained an industrial-work injury on 12-21-12. He reported initial complaints of lower backache. The injured worker was diagnosed as having lumbar radiculopathy and backache. Treatment to date has included medication, ESI (epidural steroid injection) on 5-7-13 (some relief), trigger point injection on 4-12-12, and surgery (lumbar discectomy 12-16-13). MRI results were reported on 10-31-14 revealed mild disc bulge L5, S1 and DDD (degenerative disc disease). Currently, the injured worker complains of back pain rated 5 out of 10 with medications and 8 out of 10 without. Quality of sleep is fair. Conservative treatment was opted first then consideration for a surgical candidate per surgical consultation. Medications include Ibuprofen, Norco, Zanaflex, and Lisinopril. Per the primary physician's progress report (PR-2) on 9-11-15, exam notes him to be in moderate pain, no signs of intoxication or withdrawal, global antalgic gait, no assistive devices used. The lumbar spine revealed loss of normal lordosis, restricted range of motion, positive facet loading on both sides, and positive straight leg raise at 65 degrees. Light touch sensation is decreased over the lateral foot, medial foot, and anterior thigh on the left side. Current plan of care includes conservative treatment options. The Request for Authorization requested service to include Lumbar medial branch block at left L4-5. The Utilization Review on 9-24-15 denied the request for Lumbar medial branch block at left L4-5, per CA MTUS (California Medical Treatment Utilization Schedule) Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Lumbar medial branch block at left L4-5: Upheld**

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

**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: Thoracic and Lumbar, Facet joint Mediated Blocks.

**Decision rationale:** No more than one set of medial branch diagnostic blocks is recommended 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. Facet joint medial branch blocks are not recommended for therapeutic use. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). 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. Etiology of false positive blocks is: Placebo response, use of sedation, liberal use of local anesthetic, and spread of injectate to other pain generators. The concomitant use of sedative during the block can also interfere with an accurate diagnosis. 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. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. In this case, documentation in the medical record supports the diagnosis of radiculopathy with dermatomal hypoesthesia and decreased motor function in the L5 distribution. Criteria for medical branch block have not been met. The request is not medically necessary and should not be authorized.