

<b>Case Number:</b>	CM15-0202876		
<b>Date Assigned:</b>	10/19/2015	<b>Date of Injury:</b>	02/04/2014
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	10/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2015

### 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:

This 40 year old male sustained an industrial injury on 2-4-14. Documentation indicated that the injured worker was receiving treatment for lumbago with lumbosacral spondylosis. Previous treatment included physical therapy, injections and medications. In a consultation dated 9-22-15, the injured worker complained of right sided low back pain with radiation to the left leg associated with numbness and tingling. The injured worker reported that the pain worsened with sitting too long, standing, twisting or with wearing a utility belt. The physician documented that lumbar magnetic resonance imaging (4-10-14) showed normal discs and facet arthropathy in the lower lumbar spine without major neural compression. Physical exam was remarkable for lumbar spine with right sided tenderness to palpation, "good" range of motion in the lumbar spine with moderate pain on motion, 5 out of 5 motor strength in all muscle groups and "normal" deep tendon reflexes. The physician noted a focal sensory defect to pinprick (site unspecified). The physician stated that the injured worker's complaint of numbness and tingling on the outside of the left thigh sounded like meralgia paresthetica. The physician documented, "in short, he has mechanical right sided back pain with some numbness and tingling on the lateral calf". The physician noted that the injured worker had never had injections with Cortisone. The physician recommended being careful when bending, lifting and twisting, a course of physical therapy, a prescription for Mobic and Robaxin and right sided facet joint injections at L4-5 and L5-S1 with cortisone. On 10-5-15, Utilization Review noncertified a request for right facet block injection at L4-5 and L5-S1 with Cortisone.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Facet Block Injection L4-L5, L5-S1 with Cortisone: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Occupational Disability Guidelines 9ODG) online, 4th edition, criteria for the use of diagnostic blocks for facet mediated pain.

**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 chapter 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. In this case, the claimant received MBB in January 2015 with substantial improvement for a few hours after which the pain returned to baseline. The claimant does have confirmed facet pain. 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. According to the ACOEM guidelines, blocks are not recommended due to their short-term benefit. In this case, the claimant did have substantial benefit from MBB performed in January 2015. However, there is no indication to repeat it for diagnostic purposes and the pain benefit is very short. As a result, the request for another facet block is not medically necessary.