

<b>Case Number:</b>	CM15-0033802		
<b>Date Assigned:</b>	02/27/2015	<b>Date of Injury:</b>	08/12/2003
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/23/2015

### 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: Ohio, North Carolina, Virginia  
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 52-year-old female, who sustained an industrial injury on 8/12/2003. The mechanism of injury was not noted. The diagnoses have included thoracic or lumbosacral neuritis or radiculitis, unspecified. Treatment to date has included conservative measures. Currently, the injured worker complains of low back and right leg pain. She reported right leg numbness with prolonged sitting, medications working well, and poor sleep quality due to pain. Pain was rated 7/10. Magnetic resonance imaging of the lumbar spine (6/24/2010) was documented as showing L2-3 broad based disc bulge (5mm), which in conjunction with facet hypertrophy, ligamentum flavum laxity, and retrolisthesis of L2 on L3, produces mild bilateral neural foraminal narrowing and mild central canal narrowing. L3-4 concentric broad based disc bulge (4mm), in conjunction with facet hypertrophy, ligamentum flavum laxity, produces mild central canal narrowing, moderate right neural foraminal narrowing, and mild to moderate left neural foraminal narrowing. Levoconvex lumbar curvature with its apex at approximately L3 was documented. L4-5 concentric broad based disc bulge (5mm), in conjunction with facet hypertrophy, ligamentum flavum laxity, and grade 1 anterolisthesis of L4 on L5, produces moderate right neural foraminal narrowing, mild to moderate central canal narrowing, and mild left neural foraminal narrowing. L5-S1 concentric broad based disc bulge (3mm), in conjunction with facet hypertrophy and ligamentum flavum laxity, produces mild central canal narrowing, mild bilateral neural foraminal narrowing. A signed impression report of lumbar magnetic resonance imaging (7/01/2014) noted degenerative changes and no development of severe central canal or neuroforaminal stenosis. Current medications included Ibuprofen, Lidoderm

patch, Omeprazole, and Tylenol #3. Body mass index was 43.5%. Exam noted lumbar paraspinal muscle tenderness with spasm. Exam was noted as unchanged from prior visit. Prior visit, 8/04/2014, noted a normal gait, palpable tenderness of the lower lumbar spine, intact sensory to bilateral lower extremities, decreased range of motion, and lower extremity motor strength 5/5. On 2/18/2014, Utilization Review non-certified a request for 1 right medial branch block at the L2, L3, L4, and L5 levels, noting the lack of compliance with MTUS Chronic Pain Medical Treatment Guidelines.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Right Medial Branch Block at The L2, L3, L4 and L5 Levels: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines. Low Back Chapter. Facet joints diagnostic blocks section.

**Decision rationale:** The Official Disability Guidelines 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 (MBB). MBB procedure: The technique for medial branch blocks in the lumbar region requires a block of 2 medial branch nerves (MBN). The recommendation is the following: (1) L1-L2 (T12 and L1 MBN); (2) L2-L3 (L1 and L2 MBN); (3) L3-L4 (L2 and L3 MBN); (4) L4-L5 (L3 and L4 MBN); (5) L5-S1: the L4 and L5 MBN are blocked, and it is recommended that S1 nerve be blocked at the superior articular process. Blocking two joints such as L3-4 and L4-5 will require blocks of three nerves (L2, L3 and L4). Blocking L4-5 and L5-S1 will require blocks of L3, L4, L5 with the option of blocking S1. 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). In this instance, it appears that the injured worker has not previously had a diagnostic medial branch block. She appears to meet criteria for diagnostic medial branch blocks. However, the proposed nerve root levels to block are at L2, L3, L4, and L5. Per the above discussion, this would require blocking 3 joint levels. A note from the orthopedic surgeon from 8-4-14 suggested medial branch blocks at 3 joint levels, L2-L3, L3-L4, and L5-S1, to accomplish this. The guidelines clearly allow for a maximum of two joint levels to be blocked in

one session. Therefore, right medial branch blocks at the L2, L3, L4, and L5 levels, inclusive and in one setting, are not medically necessary per the cited guidelines.