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| <b>Case Number:</b>   | CM15-0089194 |                              |            |
| <b>Date Assigned:</b> | 05/13/2015   | <b>Date of Injury:</b>       | 06/17/2005 |
| <b>Decision Date:</b> | 06/22/2015   | <b>UR Denial Date:</b>       | 04/29/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/08/2015 |

### 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 65 year old female who sustained an industrial injury on 06/17/05. Initial complaints and diagnoses are not available. Treatments to date include medications, back surgery, and sacroiliac radiofrequency ablations, the latest of which provided relief of pain for 4 months. Diagnostic studies include a CT scan of the Sacroiliac joint reportedly on 05/20/11 with no records available for review in the submitted documentation. Current complaints are not addressed. Current diagnoses include sacroilitis, spasm of the right muscle, post laminectomy syndrome, and lumbosacral spondylosis. In a progress note dated 04/23/15 the treating provider reports the plan of care as medications including Celebrex, flector patches, Baclofen, Lyrica, tramadol, and Nucynta, as well as a right medical branch block at L3-L5. The requested treatment is a right medical branch block at L3-L5.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Medical Branch Block at L3, 4, and 5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Facet joint diagnostic blocks (injections) and Other Medical Treatment Guidelines Up to Date, Subacute and chronic low back pain: Nonsurgical interventional treatment.

**Decision rationale:** MTUS is silent regarding medial branch diagnostic blocks. ODG recommends 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. Medical records indicate residual pain of back, that is non-radicular in nature. Medical documents do not include the results of conservative treatment. The treating physician does write that patient's current medications control pain and allow the patient to work. ACOEM additionally states, "does not recommend Diagnostic Blocks." Similarly, Up to Date states, "Facet joint injection and medial branch block Glucocorticoid injections into the facet joint have not been shown to be effective in the treatment of low back pain. A 2009 American Pain Society guideline recommends against their use." The provided medical documentation provided indicates this patient is awaiting SI joint fusion. Guidelines recommend against blocks if the patient has a pending surgical procedure. It is unclear if the requested block is for diagnostic or therapeutic purposes. As such, the request for Right Medial Branch Block at L3, 4, and 5 is not medically necessary.