

<b>Case Number:</b>	CM14-0125781		
<b>Date Assigned:</b>	09/26/2014	<b>Date of Injury:</b>	03/16/2004
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	07/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2014

### 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. The expert reviewer is Board Certified in Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 45-year-old man who sustained a work related injury on March 16, 2004. Subsequently, he developed chronic low back pain. According to a medical evaluation dated July 9, 2014, the patient complains of a constant low back pain. The pain radiates down the bilateral lower extremities. The patient's pain is accompanied by numbness constantly in the bilateral lower extremities (hips, thighs, knees, calves, feet, and toes). The patient described the pain as burning, sharp, electricity sensation and moderate to severe in severity. The patient reports severe difficulty in sleep. The patient reported the presence of bowel dysfunction, constipation. He rated his pain as 10/10 without medications. Prior treatment included: physical therapy (limited benefit), acupuncture (limited benefit), chiropractic (limited benefit), LESI (limited benefit), and lumbar spine surgery (helpful). His physical examination demonstrated lumbar tenderness with reduced range of motion. The range of motion was moderately to severely limited. Pain was significantly increased with flexion and extension, rotation. Facet signs were present. Sensory examination showed decreased sensation along the L4-S1 dermatome in both lower extremities. Straight leg raise with the patient in the seated position was positive bilaterally at 45 degrees. CT Myelogram of lumbar spine dated July 22, 2013 showed a 4 mm central protruded disc at L2-3 interspace causing moderate central spinal stenosis. A 2 mm central protruded disc at L3-4 interspace causing mild central spinal stenosis. CT scan of lumbar spine W/O contrast dated April 1, 2013 showed grade I spondylolisthesis of L5 associated with canal and neural foraminal narrowing. There is bulging annulus of the discs at L3-4 and L4-5 levels. MRI of the lumbar spine dated March 14, 2007 showed diffuse disc bulge 3-4 mm at L5-S1 disc level. Anterior disc bulge 4-5 mm at L3-4 and L5-S1 disc levels. The patient was diagnosed with chronic pain, lumbar facet arthropathy, and lumbar post laminectomy syndrome. The provider requested authorization for lumbar medial branch block at bilateral level L4-S1.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **1 lumbar medial branch nerve block at bilateral level L4-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300; 309.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** According MTUS guidelines, <Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain>. According to Official Disability Guidelines (ODG) guidelines regarding facets injections, < Under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti, 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial.>. Furthermore and according to ODG guidelines, < Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: 1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion.3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time.5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. In this case, there is no documentation of facet mediated pain; there is no clear evidence or documentation that lumbar and sacral facets are main pain generator. The patient has decreased sensation in the lumbosacral distribution suggesting the diagnosis of radiculopathy. Therefore, the Medial branch block bilateral L4-S1 is not medically necessary.