

<b>Case Number:</b>	CM14-0141881		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	10/31/2002
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	08/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/02/2014

### 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 Occupational Medicine and is licensed to practice in California. 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 claimant injured his neck and upper and lower back on 10/31/02 when he slipped while carrying boxes. Lumbar medial branch nerve blocks and facet injections are under review. He has diagnoses of chronic back pain, chronic pain syndrome, lumbar degenerative disc disease, radiculopathy, spondylosis without myelopathy, myalgias/myositis, and spinal stenosis. He has ongoing low back pain with radiating symptoms down the right leg. He saw the provider on 05/09/14 and complained of back pain across the low back that was throbbing and constant but alleviated by medication. His low back was not described but he had diagnoses involving the low back. He was to see a chiropractor and continue his medications. On 05/20/14, mild Minor's signs were present bilaterally. He had full strength. He was hyperreflexic. His low back otherwise was not examined. On 05/27/14, he had tenderness and hypertonicity about the cervical region. The low back again was not examined. On 05/30/14, his low back again was not examined. On 06/20/14, he presented with low back pain with slight improvement. He still had pain down his right leg and it was exacerbated by all physical activities. His lumbar spine was not examined. He had responded favorably to chiropractic treatment but it is not clear what was being treated. On 06/25/14, he was seen for neck pain, upper back, mid back, and low back pain. His low back region was not examined. He was seen on 07/08/14 and had a normal neurologic examination. There was no examination noted for the lumbar spine. On 02/07/14, he had a QME. He also is status post carpal tunnel releases and surgery to the lumbar spine in 2012. He underwent cervical anterior discectomy and fusion in 2004 with revision surgery in 2007. There was a limited physical examination that did not include his low back. Diagnoses included sexual dysfunction, visual acuity changes, dysphagia and dysphonia pending laryngoscope. He had severe tenderness of the lower lumbar spine and moderately decreased range of motion. Faber test was negative. Bilateral facet loading (Kemp's) tests were positive.

There were no neurologic deficits. A trial of median nerve branch blocks was recommended from L3-4 through L5-S1 for consideration of RFA. The note states that he was getting significant relief of his symptoms with injections and medications and he was more active. He had evidence of nerve damage and myelomalacia in the cervical spine. He was to continue chiropractic treatment. When he was evaluated on 07/08/14, his low back was not examined. Neurologic examination was intact.

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

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

**Medial branch nerve block at right L3-4, L4-5 and L5-S1 (Injection in the paravertebral facet joint on the left side 1st level and Injection in the paravertebral facet joint on the left side, 2nd times 2): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines - Low Back Chapter

**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, medial branch nerve blocks

**Decision rationale:** The history and documentation do not objectively support the request for medial branch nerve block at right L3-4, L4-5 and L5-S1 (Injection in the paravertebral facet joint on the left side 1st level and Injection in the paravertebral facet joint on the left side, 2nd times 2). The MTUS do not address these types of injections. The ODG state "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). 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. (Cohen, 2007) (Bogduk, 2000) (Cohen2, 2007) (Manchukonda, 2007) (Dreyfuss, 2000) (Manchikanti2, 2003) (Datta, 2009).. 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, physical therapy (PT) and non-steroidal anti-inflammatory drugs (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. Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)". The notes indicate that radiofrequency is under consideration based on the results of these injections. However, in this case, regarding the request for the right low back, there are many office notes that do not document findings involving the low back such that facet joint dysfunction appears to have been clearly established. Also, regarding the request for repeat injections to the left low back, there is also no support in the guidelines for repeat injections of this type. Typically, one injection is needed to make the diagnosis and radiofrequency ablation may then be considered. Repeat diagnostic blocks are not supported. The medical necessity of these injections as requested has not been demonstrated.