

<b>Case Number:</b>	CM14-0143532		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	08/26/1997
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	08/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain 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 injured worker is a 59-year-old female with an original date of injury of August 26, 1997. The mechanism of injury was a fall to the ground that was subsequent to a student kicking the worker with both feet. The patient sustained injuries to the body regions of the left elbow, shoulder, low back, and right rib cage. The industrial diagnoses include chronic low back pain, chronic neck pain, shoulder impingement syndrome, and myofascial pain. Conservative care has consisted of topical pain medications, TENS unit, physical therapy, Ultram, and previous trigger point injections. The disputed request is for lumbar medial branch block with fluoroscopy. The adverse determination of a utilization review determination cited that exam findings were not consistent with facet joint pathology, and there was an absence of failure of recent conservative care. Therefore the criteria for facet injections were not met and the request was noncertified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient Lumbar Medial Branch Block with Fluoroscopy:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Medial Branch Block

**Decision rationale:** Lumbar medial branch blocks are not specifically addressed within the Chronic Pain Medical Treatment Guidelines. Section 9792.23.5 Low Back Complaints of the California Code of Regulations, Title 8, page 6 states the following: "The Administrative Director adopts and incorporates by reference the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) into the MTUS from the ACOEM Practice Guidelines." ACOEM Medical Practice Guidelines, 2nd edition, 2004 do not have specific recommendation regarding medial branch blocks but do state on page 300 of ACOEM Chapter 12 the following excerpt regarding injections in general: "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." The guidelines found in the California Medical Treatment and Utilization Schedule and ACOEM supersede other guidelines in the Independent Medical Review process. However, the Official Disability Guidelines can also be considered since this is a secondary guideline that is widely accepted. The California Medical Treatment and Utilization Schedule states "Treatment shall not be denied on the sole basis that the condition or injury is not addressed by the MTUS. In this situation, the claims administrator shall authorize treatment if such treatment is in accordance with other scientifically and evidence-based, peer-reviewed, medical treatment guidelines that are nationally recognized by the medical community, in accordance with subdivisions (b) and (c) of section 9792.25, and pursuant to the Utilization Review Standards found in section 9792.6 through section 9792.10." The Official Disability Guidelines Low Back Chapter state the following regarding Lumbar Facet joint diagnostic blocks (injections): "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) Etiology of false positive blocks: Placebo response (18-32%), use of sedation, liberal use of local anesthetic, and spread of injectate to other pain generators. The concomitant use of sedative during the block can also interfere with an accurate diagnosis. (Cohen, 2007) 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. (Clemans, 2005) The volume of

injectate for diagnostic medial branch blocks must be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate), as increased volume may anesthetize other potential areas of pain generation and confound the ability of the block to accurately diagnose facet pathology. Specifically, the concern is that the lateral and intermediate branches will be blocked; nerves that innervate the paraspinal muscles and fascia, ligaments, sacroiliac joints and skin. (Cohen, 2007) Intraarticular blocks also have limitations due to the fact that they can be technically challenging, and if the joint capsule ruptures, injectate may diffuse to the epidural space, intervertebral foramen, ligamentum flavum and paraspinal musculature. (Cohen, 2007) (Washington, 2005) (Manchikanti, 2003) (Dreyfuss, 2003) (BlueCross BlueShield, 2004) (Pneumatics, 2006)(Boswell, 2007) (Boswell2, 2007) A recent meta-analysis concluded that there is insufficient evidence to evaluate validity or utility of diagnostic selective nerve root block, intra-articular facet joint block, medial branch block, or sacroiliac joint block as diagnostic procedures for low back pain with or without radiculopathy. (Chou2, 2009) This study suggest that proceeding to radiofrequency denervation without a diagnostic block is the most cost-effective treatment paradigm, but does not result in the best pain outcomes. (Cohen, 2010) See also Facet joint pain, signs & symptoms; Facet joint radiofrequency neurotomy; Facet joint medial branch blocks (therapeutic injections); & Facet joint intra-articular injections (therapeutic blocks). Also see Neck Chapter and Pain Chapter. 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  $\geq 70\%$ . 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. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)]" In the case of this injured worker, there has been documentation of conservative care, contrary to what the utilization reviewer had noted. Conservative care has consisted of topical pain medications, TENS unit, physical therapy, Ultram, and previous trigger point injections. The patient has had recent lumbar x-rays on August 8, 2013, which showed lumbar degenerative disc disease, but the radiology report did not comment on facet arthropathy. There is no documentation of positive facet loading or provocative facet maneuvers on physical examination in the recent notes. Furthermore, in a progress note on date of service February 6, 2014, there is positive straight leg raise. The Official Disability Guidelines states "there should be no evidence of radicular pain, spinal stenosis, or previous fusion" for diagnostic medial branch blocks. Therefore this request is not medically necessary.

**Outpatient Caudal Epidural Injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12 Edition (web, 2014 Low Back Chapter, Facet Joint Diagnostic Injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 47.

**Decision rationale:** In a recent progress note from February 2014 there is documentation of positive straight leg raise maneuver. This is indicative of possible lumbar radiculopathy. The guidelines specify that physical exam findings should be corroborated by imaging or electrodiagnostic studies. This injured worker has no documentation of prior lower extremity electrodiagnostic studies or lumbar MRI submitted in the medical record for review. There is an x-ray available, but no recent MRI to identify neural impingement or EMG to confirm radiculopathy. Without this corroboration, this request is not medically necessary.

