

<b>Case Number:</b>	CM14-0167611		
<b>Date Assigned:</b>	10/14/2014	<b>Date of Injury:</b>	09/17/2013
<b>Decision Date:</b>	11/18/2014	<b>UR Denial Date:</b>	09/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/10/2014

### 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 Family Medicine and is licensed to practice in Ohio. 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 52-year-old male with a date of injury of September 17, 2013. He underwent a left-sided laminectomy and discectomy on June 13, 2014 at the L2-L3 and L4-L5 levels. He had 12 visits with physical therapy and had been taking anti-inflammatory medication and yet persisted with 6/10 low back pain. The physical exam reveals tenderness to palpation over the lumbar paraspinal musculature overlying the bilateral L4-L5 and L5-S1 facet joints. Range motion is painful and restricted in all planes, most particularly in extension. Pelvic rock and sustained hip flexion signs are positive. The diagnoses are lumbar facet joint arthropathy, chronic low back pain, lumbar sprain/strain, and lumbar laminectomy syndrome.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fluoroscopically Guided Diagnostic Bilateral L4-5 and Bilateral L5-S1 Facet Joint Medial Branch Block:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Guidelines

**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, Facet joint diagnostic blocks (injections) and Facet joint intra-articular injections (therapeutic blocks)

**Decision rationale:** Facet joint pain produces no reliable pain referral pattern, but it is suggested that pain from upper facet joints tends to extend to the flank, hip and upper lateral thighs, while the lower joint mediated pain tends to penetrate deeper into the thigh (generally lateral and posterior). Infrequently, pain may radiate into the lateral leg or even more rarely into the foot. Indicators of facet joint pathology include: Suggested indicators of pain related to facet joint pathology (acknowledging the contradictory findings in current research): (1) Tenderness to palpation in the paravertebral areas (over the facet region); (2) A normal sensory examination; (3) Absence of radicular findings, although pain may radiate below the knee; (4) Normal straight leg raising exam. 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 percent. 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. 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]. In this case, the history and clinical findings are consistent with facet mediated pain. The injured worker has failed conservative treatment. There is no evidence that a fusion procedure is anticipated. This is a reversal of the previous utilization review decision as the guidelines cited do not preclude this procedure in the sub-acute period following a hemilaminectomy. Therefore, fluoroscopically guided diagnostic bilateral L4-5 and bilateral L5-S1 facet joint medial branch block is medically necessary.