

<b>Case Number:</b>	CM14-0181522		
<b>Date Assigned:</b>	11/06/2014	<b>Date of Injury:</b>	07/01/2010
<b>Decision Date:</b>	12/15/2014	<b>UR Denial Date:</b>	10/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 64-year-old female who has submitted a claim for chronic pain syndrome, facet joint arthropathy, lumbar radiculopathy, and lumbar degenerative disc disease associated with an industrial injury date of 7/1/2010. Medical records from 2014 were reviewed. The patient complained of low back pain with bilateral leg pain and anterior thigh paresthesia. Pain was rated 5 to 9/10 in severity aggravated by sitting, standing, and walking. Physical examination of the lumbar spine showed tenderness, stiffness, limited motion, and positive bilateral straight leg raise test. Motor strength, reflexes, and sensory exam were unremarkable. Gait was antalgic. MRI of the lumbar spine, dated 6/13/2012, documented mild degenerative disc disease and spondylosis at L1-L2, L2-L3, L3-L4, and L5-S1 with mild central canal stenosis and foraminal narrowing at L3-L4 and L4-L5. NCV report from 12/23/2013 was unremarkable. Treatment to date has included left transforaminal injection, TENS unit, physical therapy and medications. The utilization review from 10/17/2014 denied the request for diagnostic medial branch nerve blocks at L4-5, L5-S1, and right side first followed one week later by left side because of no significant long-term functional benefit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Diagnostic medial branch nerve blocks at L4-5, L5-S1, right side first followed one week later by left side:** 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, Facet Joint Diagnostic Blocks

**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 Chapter, Medial Branch Block

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, and the Official Disability Guidelines (ODG) was used instead. It states that medial branch blocks (MBB) are not recommended for treatment except as a diagnostic tool for patients with non-radicular low back pain limited to no more than two levels bilaterally. Criteria for the use of diagnostic blocks for facet mediated pain include: (1) one set of diagnostic medial branch blocks with a response of greater than or equal to 70%; (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 prior to the procedure for at least 4-6 weeks; and (4) no more than 2 facet joint levels are injected in one session. In this case, the patient complained of low back pain with bilateral leg pain and anterior thigh paresthesia. Pain was rated 5 to 9/10 in severity aggravated by sitting, standing, and walking. Physical examination of the lumbar spine showed tenderness, stiffness, limited motion, and positive bilateral straight leg raise test. Motor strength, reflexes, and sensory exam were unremarkable. Gait was antalgic. MRI of the lumbar spine, dated 6/13/2012, documented mild degenerative disc disease and spondylosis at L1-L2, L2-L3, L3-L4, and L5-S1 with mild central canal stenosis and foraminal narrowing at L3-L4 and L4-L5. NCV report from 12/23/2013 was unremarkable. Symptoms persisted despite use of a TENS unit, physical therapy and medications. However, patient presented with low back pain radiating to lower extremities, an exclusion criterion for diagnostic MBB. Moreover, it is not reasonable to certify two sessions of MBB at this time without assessment of functional response from prior procedure. For the above reasons, the guideline criteria were not met. Therefore the request for diagnostic medial branch nerve blocks at L4-5, L5-S1, and right side first followed one week later by left side is not medically necessary.