

<b>Case Number:</b>	CM15-0172163		
<b>Date Assigned:</b>	09/14/2015	<b>Date of Injury:</b>	09/24/2011
<b>Decision Date:</b>	10/19/2015	<b>UR Denial Date:</b>	08/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/01/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 57-year-old male, who sustained an industrial injury on 9-24-11. Medical record indicated the injured worker is undergoing treatment for chronic pain, lumbar radiculopathy, status post fusion, lumbar laminectomy L4-5 and diabetes. Treatment to date has included cervical fusion, lumbar discectomy, lumbar fusion, physical therapy (provided limited benefit), acupuncture (provided limited benefit), and oral medications including Norco, Tylenol and Hydrocodone and activity modifications. (MRI) magnetic resonance imaging of lumbar spine performed on 4-17-15 revealed postoperative changes at L4-5 with endplate edema suspicious for reactive changes due to altered biomechanics, encroachment of left lateral recess due to residual disc material versus granulation tissue or other post-operative changes that impress on the descending component of left L5 nerve root in the spinal canal. Currently on 8-4-15, the injured worker complains of recently worsened, constant low back pain with radiation down bilateral lower extremities accompanied by numbness constantly in the left lower extremity and described as dull, sharp and severe. He rates the pain 10 out of 10 without medications. He is currently not working. Physical exam performed on 8-4-15 revealed tenderness on palpation in spinal vertebral area L4-S1 levels with decreased sensitivity to touch along the L5 dermatome in left lower extremity. The treatment plan included request for median branch block at L3-4. On 8-18-15, utilization review non-certified bilateral L3-4 median branch block under fluoroscopy noting the injured worker has complaints of lumbar pain despite prior care. There is limited evidence that facet tenderness at L3-4 level has been addressed and limited evidence that ongoing radicular findings were previously addressed.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Bilateral L3-L4 median branch block under fluoroscopy: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Criteria for the use of diagnostic blocks for facet "mediated" pain, Fluoroscopy.

**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).

**Decision rationale:** Per the ODG guidelines, facet joint medial branch blocks are not recommended except as a diagnostic tool, citing minimal evidence for treatment. The ODG indicates that criteria for facet joint diagnostic blocks (injections) are as follows: 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, 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)] The documentation submitted for review indicates that the injured worker indeed suffers from radiculopathy per physical exam dated 8/4/15, which noted decreased sensitivity to touch along the L5 dermatome in the left lower extremity, as well as numbness constantly in the left lower extremity. This request is not medically necessary.