MAXIMUS Federal Services

| Case Number: | CM15-0034819 | | |
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| Date Assigned: | 03/03/2015 | Date of Injury: | 09/16/2013 |
| Decision Date: | 04/10/2015 | UR Denial Date: | 02/19/2015 |
| Priority: | Standard | Application Received: | 02/24/2015 |

## 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: New Jersey, Michigan, California
Certification(s)/Specialty: Neurology, Neuromuscular Medicine

## 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 was a 59-year-old female, who sustained an industrial injury, September 16, 2013. The injured worker sustained the worker related injury when a car, the injured worker stopped, was hit from behind. The car hit the injured worker. The injured worker was thrown on the hood and into the windshield of the car. According to progress note of January 30, 2015, the injured workers chief complaint was left arm pain, aching and burning form the left shoulder into the hand. The knee pain was made worse by walking. The chief complaint was stiffness with increased pain with sneezing, coughing or straining. The injured worker rated the low back pain at 6-7 out of 10; 0 being no pain and 10 being the worse pain. The injure worker described the pain as burning, aching, sharp, throbbing, tight, shooting and stabbing. The pain was aggravated by walking, sitting, standing, and leaning forward and straining. The low back pain was better with medications, rest, exercise, heat, and relaxing. The injured worker was diagnosed with chronic pain due to trauma, left arm from shoulder down to the hand with tingling and numbness and weakness, right knee pain, pain in the neck with constant headache, generalized headaches, anxiety, depression and panic attacks. The injured worker previously received the following treatments MRI of the lumbar spine October 21, 2014 and January 6, 2015, MRI of the thoracic spine January 6, 2015, CT of the lumbar spine January 6, 2015, physical therapy, aqua therapy and pain medications. January 30, 2015, the primary treating physician requested authorization for injection of the paravertebral facet joint lumbar spine 2 levels (medical branch block bilateral L4 and L5). February 19, 2015, the Utilization Review denied authorization for injection of the

paravertebral facet joint lumbar spine 2 level (medical branch block bilateral L4 and L5). The denial was based on the MTUS/ACOEM and ODG guidelines.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Diagnostic medial branch block bilateral L4, L5:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** According MTUS guidelines, "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." According to ODG guidelines regarding facets injections, "Under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti , 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial." Furthermore and according to ODG guidelines, Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: 1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time. 5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. The ODG guidelines did not support facet injection for lumbar pain in this clinical context. There is no documentation of facet mediated pain or that facets are the main pain generator. There is no documentation of failure of conservative therapies in this patient. Therefore, the request for Diagnostic medial branch block bilateral L4, L5 is not medically necessary.