MAXIMUS Federal Services

| Case Number: | CM15-0065189 | | |
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| Date Assigned: | 04/13/2015 | Date of Injury: | 05/25/2011 |
| Decision Date: | 06/24/2015 | UR Denial Date: | 03/20/2015 |
| Priority: | Standard | Application Received: | 04/08/2015 |

## 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, Alabama, 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 is a 50 year old female patient who sustained an industrial injury on 05/25/2011. The accident is described as the worker having slipped and fallen onto her buttocks landing on the floor with resulting neck, hip and right arm/hand pains. She was evaluated, given medications, worked modified duty. A magnetic resonance imaging (MRI) study of the right hip performed on 09/26/2011 showed negative acute results. A MRI of the cervical spine done on 12/02/2011 showed degenerative disc changes with disc protrusions at multiple levels and partial effacement of the CSF space surrounding the cord at C4-5 with mild to moderate right and minor left neural foraminal narrowing, and minor narrowing of the spinal canal; right neural foramen at C5-6. An orthopedic evaluation dated 11/10/2014 reported the patient current working full duty. On 05/22/2012 she was administered a cervical translaminar injection at C7-T1, right with note of neck and right arm symptoms improved significantly for about six months. Electrodiagnsotic nerve conduction study performed on 08/01/2012 revealed no evidence of lumbar radiculopathy. A follow up MRI of lumbar spine obtained on 10/25/2013 showed an L4- 5 broad based disc bulge with posterior superimposed central annular fissure and mild bilateral neural foraminal narrowing along with facet hypertrophy and ligamentus flava laxity producing mild central canal narrowing. Again, on 07/2014 she underwent administration of a sacroiliac epidural injection which has helped her symptom through this visit. Current medications are: Diazepam, Tramadol, Gabapentin, and Lansoprazole. The impression found the patient with cervical strain with radicular pain; degenerative disc disease; right elbow contusion/strain, resolved; lumbosacral strain with radicular pain; degenerative disc disease, and right ankle strain. The patient noted deemed permanent and stationary this visit.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Right L3, L4, L5, S1 medial branch block qty: 4:** 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." In this case, there is no clear evidence that lumbar facets are the main pain generator. The diagnosis of radiculopathy or spinal stenosis was not fully excluded in this case. Therefore, the request for Right L3, L4, L5, S1 medial branch block is not medically necessary.