

<b>Case Number:</b>	CM14-0082521		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	08/19/2013
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	05/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/03/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 who reported an injury on 08/19/2013. The mechanism of injury was not provided. On 08/15/2014, the injured worker presented with right low back pain. Current medications included Celebrex and Metformin. On examination of the lumbar spine, there was restricted range of motion due to pain, a positive straight leg raise to the right, and a positive lumbar facet loading on the right side. There was decreased sensation to the right lateral thigh. The diagnoses were lumbago and facet syndrome. Prior therapy included physical therapy and NSAIDs. The provider recommended 1 right L4-5 and L5-S1 medial branch block, 6 monthly medication assessments, and Voltaren gel. The provider's rationale was not provided. The Request for Authorization Form was dated 08/18/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 right L4-L5 and L5-S1 medial branch block:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 309.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Facet Joint Diagnostic Block.

**Decision rationale:** The California MTUS/ACOEM Guidelines state diagnostic injections may have benefited the injured worker presenting in the transitional phase between acute and chronic pain. The Official Disability Guidelines further state that criteria for use of diagnostic blocks is limited to injured workers with pain that is non-radicular, no more than 2 joint levels injected in 1 session, there must be evidence of failure of conservative treatment to include home exercise, physical therapy, and NSAIDs prior to the procedure for at least 4 to 6 weeks. The provider noted a positive lumbar facet loading and a positive right-sided straight leg raise. There is decreased sensation to the anterolateral right thigh and restricted range of motion due to pain. Radiculopathy is an exclusionary criterion for a medial branch block. Additionally, there is a lack of evidence of the efficacy of the prior conservative treatment provided and the length of time used for conservative care. As such, the request is not medically necessary.

**6 monthly medication assessments:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office Visit.

**Decision rationale:** The Official Disability Guidelines recommend office visits for proper diagnosis and return to function of an injured worker. The need for a clinical office visit with a healthcare provider is individualized based upon a review of the injured worker's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. As the injured workers conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best injured worker outcomes are achieved with eventual injured worker independence from the healthcare system through self-care as soon as clinically feasible. The provider's request for 6 monthly medication assessments is excessive and the provider does not provide a rationale for the request. As such, the request is not medically necessary.

**Voltaren 1% gel #200:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The California MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not

recommended is not recommended. Voltaren is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. The recommended use is 4 to 12 weeks. The injured worker does not have a diagnosis congruent with the guideline recommendation of Voltaren gel. Additionally, there is a lack of evidence that the injured worker failed a trial of an anticonvulsant or antidepressant. The provider's request needs more clarification as to the dose, quantity, and frequency of the Voltaren gel as well as the site that it is indicated for in the request as submitted. As such, the request is not medically necessary.