Case Number:	CM15-0168482		
Date Assigned:	09/09/2015	**Date of Injury:**	04/12/2008
Decision Date:	10/13/2015	**UR Denial Date:**	08/13/2015
Priority:	Standard	**Application Received:**	08/26/2015

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
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 49-year-old male who sustained an industrial injury on 04-12-2008. The injured worker was re-evaluated for low back pain radiating into the left buttock and into the left lateral thigh and for left lateral calf radicular pain. He reported aggravated bilateral low back pain. Exacerbating factors included prolonged sitting and standing, lifting, twisting, driving, any activities, lying down, coughing, sneezing and bearing down. Current medications included Norco and Ambien. A urine drug screen on 06-23-2015 was consistent with medications. Prior medications included Senokot, Soma, Lorazepam, Ibuprofen, Neurontin, Cymbalta, Vicodin and Lexapro. Past medical history included left ankle surgery x 2 in 2009 and 2010 and left knee surgery in 2009. Physical examination demonstrated lumbar and left ankle ranges of motion were restricted by pain in all directions. There was tenderness upon palpation of the left ankle, right knee and paraspinal muscles overlying the L1 to L4 region. There was tenderness upon palpation of the left buttock and left sacroiliac joint. There was tenderness upon palpation of the left and right knee. Lumbar discogenic and left ankle provocative maneuvers were positive. Left sacroiliac joint provocative maneuvers including Yeoman's, Gaenslen's and tenderness at the sacral sulcus were positive. Nerve root tension signs were negative bilaterally. Muscle stretch reflexes were 1 and symmetric bilaterally in the lower extremities. Clonus, Babinski's, and Hoffman's signs were absent bilaterally. Muscle strength was 5 out of 5 in the right lower extremity. Impression included right knee pain, chronic left knee pain, bilateral lumbar facet joint pain at L4-5, L5-S1, lumbar facet joint arthropathy, status post fluoroscopically guided left sacroiliac joint radio frequency nerve ablation, status post left knee surgery, left knee pain, left

sacroiliac joint pain as diagnosed by positive diagnostic left sacroiliac joint injection, L5-S1 disc protrusion measuring 2 millimeters with L5 neural foraminal stenosis, mild degenerative disc disease at L5-S1, lumbar spine industrial injury to altered gait from industrial left ankle injury, lumbar stenosis, lumbar facet joint arthropathy, lumbar sprain strain, status post left ankle surgery, left ankle derangement, psyche and gastroesophageal reflux disease. The treatment plan included testosterone supplementation, a fluoroscopically-guided diagnostic bilateral L4-L5 and L5-S1 facet joint medial branch block to evaluate for the presence of lumbar facet joint pain as the reason for the low back pain symptoms. The provider state, "the physical examination has supporting findings of lumbar extension being more painful than flexion and tenderness upon palpation of the lumbar paraspinal muscles overlying the bilateral L4-L5 and L5-S1 facet joints". "The patient has failed physical therapy, NSAIDS and conservative treatment." A fluoroscopically guided left knee superolateral, superomedial and inferomedial genicular nerve block to treat the injured worker's chronic left knee was also recommended. The provider noted that the injured worker had failed surgical and non-surgical treatments. Prescriptions for Norco and Ambien were provided. Work status included temporary total disability for the lumbar spine injury. Work restrictions included no bending, twisting or lifting. He was supposed to return for follow up in 4 weeks. There were no radiographic imaging reports submitted for review. On 08-13-2015 Utilization Review non-certified, the request for outpatient left knee superolateral, superomedial, and inferomedial genicular nerve block with fluoroscopy noting, "peripheral nerve block injection-neurotomies are not recommended".

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient left knee superolateral, superomedial, and inferomedial genicular nerve block with 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) Treatment Index 13th Edition (web) 2015 Knee and Lower Leg.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic) Chapter, under Genicular nerve block.

Decision rationale: The patient presents on 07/21/15 with bilateral lower back pain, which radiates into the left lower extremity. The patient's date of injury is 04/12/08. Patient is status post left ankle surgery in 2009 and 2010, and status post left knee surgery in 2009. The request is for OUTPATIENT LEFT KNEE SUPEROLATERAL, SUPEROMEDIAL, and AND INFEROMEDIAL GENICULAR NERVE BLOCK WITH FLUOROSCOPY. The RFA is dated 08/05/15. Physical examination dated 07/21/15 reveals tenderness to palpation of the left ankle, right knee, left buttock, left SI joint, and lumbar paraspinal muscles from L1 to L4. The provider also notes positive Yeoman's sign, Gaenslen's sign, and tenderness in the sacral sulcus. The patient is currently prescribed Norco and Ambien. Patient is currently classified as temporarily totally disabled. ODG-TWC, Knee & Leg (Acute & Chronic) Chapter, under Genicular nerve block: See Radiofrequency neurotomy (of genicular nerves in knee). Radiofrequency neurotomy

states: Not recommended until higher quality studies with longer follow-up periods are available, to demonstrate the efficacy of radiofrequency genicular neurotomy but also to track any long- term adverse effects. In one small study RF neurotomy of genicular nerves led to significant pain reduction and functional improvement in elderly patients with chronic knee OA pain who had a positive response to a diagnostic genicular nerve block, but they concluded that further trials with a larger sample size and longer follow-up were recommended. In regard to the genicular nerve block, such neurotomy procedures are not supported by guidelines at this time. This patient presents with significant and ongoing left lower extremity pain and a significant surgical history in the extremity. In this case, the provider has been seeking a genicular nerve block since at least 07/08/14. While the provider feels as though this is the best course of action for this patient, such procedures are not considered appropriate until higher quality studies clearly demonstrate glenicular neurotomy as an effective treatment option. Owing to a lack of guideline support for the requested procedure, the request IS NOT medically necessary.