

<b>Case Number:</b>	CM15-0185579		
<b>Date Assigned:</b>	09/28/2015	<b>Date of Injury:</b>	12/01/2010
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	09/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

This is a 41-year-old female whose date of injury was December 1, 2010. Medical documentation indicated the injured worker was treated for lumbar degenerative disc disease, post laminectomy syndrome, lumbar radiculopathy and myofascial pain syndrome. The injured worker was evaluated for leg pain and low back pain. She had L5-S1 laminectomy and fusion in July, 2013. Imaging on October 11, 2012 revealed fusion hardware at L5-S1 interspace with moderate bilateral subarticular stenosis and mild bilateral foraminal narrowing. She rated her pain a 7 on a 10-point scale and noted bilateral buttock pain. Her medication regimen included Xanax 0.5 mg, gabapentin 300 mg, Prevacid 30 mg, Norco 7.5-325 mg and Ambien 5 mg. She used Prevacid 30 mg for medicine-induced gastritis and noted that with Prevacid 30 mg every day she is able to control her stomach issues. She had gastric sleeve surgery, which also promoted gastritis. Other treatments included physical therapy without improvement, TENS unit, psychotherapy and failed nortriptyline use. On 7-24-14, she had lumbar transforaminal epidural steroid injection with no lasting relief. Objective findings included tenderness to palpation over the lumbar spinous processes. She had limited extension of the lumbar spine with pain on extension and axial rotation to the left and right. Straight leg raise was positive bilaterally and her strength was 5-5 in the bilateral lower extremities. Her sensation was equal and normal and reflexes were appropriate. A request for authorization for diagnostic bilateral L4-5 and L5-S1 medial branch block and Prevacid 30 mg #60 was received on September 3, 2015. On September 11, 2015, the Utilization Review physician determined diagnostic bilateral L4-5 and L5-S1 medial branch block and Prevacid 30 mg based on Official Disability Guidelines and CA MTUS ACOEM.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Diagnostic bilateral L4-5 and L5-S1 medial branch block: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability guidelines, Facet joint diagnostic blocks.

**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 under Medical Branch Blocks, Diagnostic.

**Decision rationale:** The claimant was injured now five years ago with lumbar degenerative disc disease, post laminectomy syndrome, lumbar radiculopathy and myofascial pain syndrome. She used Prevacid 30 mg for medicine-induced gastritis and noted that with it, she is able to control her stomach issues. She had gastric sleeve surgery, which also promoted gastritis. An epidural gave no lasting relief. She had limited extension of the lumbar spine with pain on extension and axial rotation to the left and right. Straight leg raise was positive bilaterally. The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. The ODG notes: Criteria for the use of diagnostic blocks for facet "mediated" pain: 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 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 joint levels are injected in one session (see above for medial branch block levels). 5. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 6. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. In this case, the pain is radicular in nature [criterion 2 failure]. In addition, the surgical plans in this claimant are not clear [criterion 5 failure]. The request is appropriately not medically necessary.

### **Prevacid 30mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** The claimant was injured now five years ago with lumbar degenerative disc disease, post laminectomy syndrome, lumbar radiculopathy and myofascial pain syndrome. She used Prevacid 30 mg for medicine-induced gastritis and noted that with it, she is able to control her stomach issues. However, she had gastric sleeve surgery, which also promoted gastritis. An epidural gave no lasting relief. She had limited extension of the lumbar spine with pain on extension and axial rotation to the left and right. Straight leg raise was positive bilaterally. The MTUS speaks to the use of Proton Pump Inhibitors like in this case in the context of Non

Steroid Anti-inflammatory Prescription. It notes that clinicians should weigh the indications for NSAIDs against gastrointestinal risk factors such as: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Sufficient gastrointestinal risks are not noted in these records. The request is appropriately not medically necessary based on MTUS guideline review.