

Case Number:	CM14-0143500		
Date Assigned:	09/10/2014	Date of Injury:	09/30/1998
Decision Date:	10/10/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/04/2014

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 Occupational Medicine and is licensed to practice in California. 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:

This is a 53-year-old female with a 9/30/98 date of injury. The patient was most recently seen on 8/6/2014 by a pain management specialist with complaints of worsening lumbar and right hip pain, in addition to bilateral sciatica, limiting her activities of daily living, i.e. walking. Current pain level was noted as 5-10/10, while previous pain level was 7-10/10. The note states that the patient had not responded to conservative treatment, which included NSAIDs, opiates, and home exercise program. Exam findings revealed a normal gait and point tenderness over the L2-L3 facets. The lumbar spine exam showed forward flexion to 65 degrees, hyperextension to 15 degrees, right and left lateral bend to 15 degrees, with normal squatting and a negative straight leg raise. Bilateral lower extremity motor strength was 5/5 except for the right quadriceps, which was 4+/5. The sensory exam revealed decreased sensation to pin on right L5 and left S1, and decreased light touch on both lower extremities. Deep tendon reflexes in bilateral lower extremities were normal. The patient's diagnoses included right lumbar radiculopathy, lumbar facet arthropathy, degenerated disc disease (lumbar), and lumbosacral sprain/strain. The current medications included Vimovo 375/20mg PO BID PRN, Voltaren 1% gel, Lidoderm 5% patch, Norco 10/325mg PO QID, Fentanyl 25mcg/hr patch, and Valium 5mg PO qHS PRN. The treatment plan included continuation of current medications, home exercise program, stretches, and moist heat. A pain management note dated 3/12/2014 stated that a previous radiofrequency ablation provided more than a 75% improvement in pain for the patient, lasting more than a year. The level of the previous radiofrequency ablation was not specified. No MRI studies or plain films were noted. Treatment to date: medications, home exercise program, stretches, moist heat. An adverse determination was received on 8/22/2014 due to insufficient documentation of a failure of specific conservative treatment (including home exercise, physical therapy, and NSAIDs) prior to the procedure for at least 4-6 weeks, lack of documentation of red flags for

fracture or serious systemic illness. Furthermore, the use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral lumbar medial branch Lf-L2, L2-L3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG), Low Back Chapter, Facet Joi.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Low Back Chapter-Medial Branch Blocks)

Decision rationale: Official Disability Guidelines (ODG) states that medial branch blocks are not recommended except as a diagnostic tool for patients with non-radicular low back pain limited to no more than two levels bilaterally; conservative treatment prior to the procedure for at least 4-6 weeks; and no more than 2 joint levels are injected in one session. The pain management progress notes stated that the patient was experiencing worsening lumbar and right hip pain, which limited her activities of daily living. On exam the patient had facet joint tenderness over L2/L3, but not L1/L2. The patient was on NSAIDs and opiates, in addition to a home exercise program, however, it is not clear what further measures of conservative therapy (i.e. PT, acupuncture, chiropractic therapy) have taken place, as this was not documented. In addition, the documentation lacked sufficient information in regards to the previous radiofrequency ablation procedure, specifically the level at which the procedure was done. Therefore, the request for a bilateral lumbar medial branch block at L1-L2, L2-L3 was not medically necessary.