MAXIMUS Federal Services

Case Number:	CM14-0146980		
Date Assigned:	09/15/2014	Date of Injury:	10/16/2000
Decision Date:	10/15/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	09/10/2014

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 and Pain 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:

The injured worker is a 69-year-old female who sustained an injury on 10/16/00. As per the report of 9/9/14, she complained of bilateral low back pain radiating to left buttock and posterior left thigh. Sitting, lying on side and lifting worsens the pain; stretching and medications eases the pain. Exam revealed tenderness upon palpation of the left lumbar paraspinal muscles overlying the left L4-5 and L5-S1 facet joints and left sacrum, and tenderness upon palpation of the bilateral cervical paraspinal muscles. Peripheral pulses were 2+ bilaterally. Lumbar ROM was restricted by pain; extension was worse than flexion. Lumbar discogenic provocative maneuver sustained hip flexion was positive bilaterally. Sacroiliac provocative maneuvers, Gaenslen's, Patrick's maneuver, iliac gapping and Yeoman's were positive in the left; pressure at the sacral sulcus was positive bilaterally. She had fusion T10-S1 with several revision surgeries. Current medications include Effexor XR 150 (bid), Clonazepam 1mg (bid), Topiramate 25mg (bid), Atenolol 50mg, Calcium 300mg, Vitamin C 1000mg, and Tramadol 37.5/325mg (bid). Past medications include OxyContin 10mg (bid), Gabapentin 300mg (tid) and Oxycodone 20mg. Past treatments include left SI joint injection with 100% pain relief, failed physical therapy, NSAIDs, and conservative treatments. UDS were consistent with no aberrant behaviors. Diagnoses: L3-4, L4-5, L5-S1 fusion; facet joint pain at left L4-5, L5-S1, status post positive fluoroscopically guided diagnostic left sacroiliac joint injection; upper cervical bilateral facet joint pain; upper cervical bilateral facet joint arthropathy; cervical sprain/strain; left sacroiliac joint pain; lumbar post-laminectomy syndrome; lumbar facet joint arthropathy; and neuropathic pain. The request for fluoroscopically guided diagnostic left L4-L5 facet joint medical branch block; fluoroscopically guided diagnostic left L5-S1 facet joint medical branch block; moderate sedation services; and Tramadol 37.5/325mg #60 were denied on 9/4/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluoroscopically guided diagnostic left L4-L5 facet joint medical 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, Low Back Chapter, updated 7/03/14, Medial Branch 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

Decision rationale: CA MTUS do not discuss the issue in dispute and hence ODG have been consulted. As per ODG, lumbar medial branch block is limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. Clinical presentation should be consistent with facet joint pain, signs & symptoms. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine. Limited to patients with non-radicular pain and at no more than two levels bilaterally. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. No more than 2 joint levels are injected in one session. In this case, there is evidence of radicular pain, and no clear signs and symptoms of facet mediated pain as the IW has had multiple surgeries causing post-surgical paraspinal tenderness. There is little to no documentation of at least 4-6 weeks of conservative treatment such as physical therapy and there is no imaging evidence of facet arthropathy therefore this treatment is not medically necessary.

Fluoroscopically guided diagnostic left L5-S1 facet joint medical 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, Low Back Chapter, updated 7/03/14, Medial Branch 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

Decision rationale: CA MTUS do not discuss the issue in dispute and hence ODG have been consulted. As per ODG, lumbar medial branch block is limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. Clinical presentation should be consistent with facet joint pain, signs & symptoms. One set of diagnostic medial branch blocks is required with a response 70%. The pain response should be approximately 2 hours for Lidocaine. Limited to patients with non-radicular pain and at no more than two levels bilaterally. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. No more than 2 joint levels are injected in one session. In this case, there is evidence of radicular pain and no clear signs and symptoms of facet mediated pain as the IW has had multiple surgeries causing post-surgical paraspinal tenderness. There is little to no documentation of at least 4-6 weeks of conservative treatment such as

physical therapy and there is no imaging evidence of facet arthropathy therefore this treatment is not medically necessary.

Moderate sedation services: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, updated 7/03/14, Medial Branch Blocks

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary

Tramadol 37.5/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids, Tramadol Page(s): 78, 93-94. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Tramadol (Ultram)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 91.

Decision rationale: According to the CA MTUS Guidelines, Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic, it is indicated for moderate to severe pain. The CA MTUS Guidelines indicate "four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids; pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors)." The guidelines state opioids may be continued: (a) if the patient has returned to work and (b) if the patient has improved functioning and pain. In this case, the clinical information is limited and there little to no documentation any significant improvement in pain level (i.e. VAS) and function with prior use. There is no evidence of urine drug test in order to monitor compliance. There is no evidence of alternative means of pain management such as home exercise program or modalities such as hot/cold. Therefore, the medical necessity of Tramadol has not been established.