

Case Number:	CM13-0066482		
Date Assigned:	06/09/2014	Date of Injury:	02/02/2001
Decision Date:	08/05/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	12/16/2013

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 Anesthesia, has a subspecialty in Acupuncture 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 48 years old male with date of injury 2/2/01 with related thoracic and low back pain. Per progress report dated 4/28/14, the pain radiated down the bilateral lower extremities. He rated his pain as 6/10 in intensity with medications, 9/10 without. The injured worker complained of frequent and severe muscle spasms in the low back. He reported insomnia with ongoing pain. Per physical exam of the thoracic spine, there was spasm noted in the bilateral T5-T8 paraspinal muscle. Tenderness was noted in the paravertebral region T5-T11. Myofascial trigger points were noted in the lower midback bilaterally and in the upper mid back bilaterally. Positive facet signs noted at T11-T12. Per physical exam of the lumbar spine, tenderness was noted upon palpation bilaterally in the in the paravertebral area L1-L4 levels. The range of motion of the lumbar spine was severely limited secondary to pain. Pain was significantly increased with extension, flexion. Facet signs were present. Sensory exam was within normal limits bilaterally. Motor exam was within normal limits in bilateral lower extremities. The patient's achilles and patellar reflexes were within normal limits bilaterally. Straight leg raise with the patient in the seated position was positive bilaterally at 40 degrees. MRI of the thoracic spine dated 1/10/03 revealed advanced discogenic disease at T11-T12 with loss of disc height and disc signal. There was a broad-based 3mm bar extending to, but not significantly compromising the cord. There was discogenic disease at T6-T7. He is status post lumbar fusion at L4-L5, thoracic spine fusion at T6-T7 and T11-T12. Treatment to date has included physical therapy, lumbar epidural steroid injection, TENS, and medication management. The date of UR decision was 11/2/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL 10-11 RADIO-FREQUENCY RHIZOTOMY: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Rhizotomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic, Facet Joint Radiofrequency Neurotomy.

Decision rationale: Per MTUS ACOEM, " There is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain...Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks" but beyond that MTUS is silent on specific requirements for RF ablation in the cervical spine. Per ODG with regard to facet joint radiofrequency neurotomy: Under study. Conflicting evidence, which is primarily observational, is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis. Studies have not demonstrated improved function. The ODG indicates that criteria for cervical facet joint radiofrequency neurotomy are as follows: 1. Treatment requires a diagnosis of facet joint pain. See Facet joint diagnostic blocks. 2. Approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function. 3. No more than two joint levels are to be performed at one time (See Facet joint diagnostic blocks). 4. If different regions require neural blockade, these should be performed at intervals of not sooner than one week, and preferably 2 weeks for most blocks. 5. There should be evidence of a formal plan of rehabilitation in addition to facet joint therapy. 6. While repeat neurotomies may be required, they should not be required at an interval of less than 6 months from the first procedure. Duration of effect after the first neurotomy should be documented for at least 12 weeks at >50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period. Per the most recent progress report, positive facet signs were noted at T11-T12. It was noted that the injured worker had successful response to diagnostic facet joint injection with about 80%-90% pain relief for a short period of time. I respectfully disagree with the UR physician's assertion that this treatment is not recommended by the MTUS or ODG guidelines, as cited above it is stated that it is supported by medical literature and recommended on a case-by-case basis. As the criteria are met, the request is medically necessary.

DME: INTERFERENTIAL UNIT 60 DAY RENTAL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION. Decision based on Non-MTUS Citation ACOEM, PAGE 114 AND OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, K INTERFERENTIAL CURRENT STIMULATION.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION Page(s): 118.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines with regard to interferential current stimulation: Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. As the requested treatment is not recommended by the MTUS, and has only limited evidence of improvement when used in conjunction with other recommended treatments, the request is not medically necessary.

AMBIEN 10 MG, QTY: 20: 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) Pain Chapter, Ambien (zolpidem).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN (CHRONIC), ZOLPIDEM (AMBIEN).

Decision rationale: The MTUS is silent on the treatment of insomnia. With regard to Ambien, the ODG guidelines state Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. The documentation submitted for review do not contain information regarding sleep onset, sleep maintenance, sleep quality, and next-day functioning. It was not noted whether simple sleep hygiene methods were tried and failed. The request is not medically necessary.

BACLOFEN 10 MG, QTY: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, NON-SEDATING MUSCLE RELAXANTS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63-64.

Decision rationale: With regard to muscle relaxants, the MTUS Chronic Pain Medical Treatment Guidelines states: Recommend non-sedating muscle relaxants with caution as a

second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Regarding Baclofen: It is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. As the documentation provided for review does not indicate that the injured worker has multiple sclerosis or spinal cord injury, which are the conditions for which Baclofen is recommended. Therefore, the request is not medically necessary.