

Case Number:	CM14-0168131		
Date Assigned:	10/15/2014	Date of Injury:	08/24/1988
Decision Date:	12/08/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/13/2014

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 Family 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 67-year woman has longstanding low back pain, with date of injury of 8/24/1988. No mechanism of injury is described in the available records. The records contain a single progress note dated 9/9/14, signed by a nurse practitioner. It documents that the patient had a microdiscectomy in about 1994. She did well until about 2011, and then had recurrence of pain. She had radiofrequency ablation (RFA) at L2, 3,4,5 in May of 2013, and reports 80% pain relief. She also reports that she gained benefit from lumbar epidural steroid injections (ESI's). Currently, she complains of constant low back pain radiating to the R lower extremity, which has been present for about three months. She has been incontinent of bladder and bowel for 1-2 years. Walking is limited and stooping while holding onto a grocery cart allows her to walk further. Exam is essentially normal, with normal range of motion of the back and lower extremity joints, normal strength, sensation and deep tendon reflexes. Straight leg raise on the right causes right lower extremity pain. A facet loading test is documented as positive. Diagnoses include lumbosacral disc degeneration, lumbosacral spondylosis, and lumbar or thoracic radiculitis. The plan includes deferring any repeat MRI, repeating right transforaminal ESI's at L4-5 and L5-S1, and repeating bilateral RFA's at L2, 3,4,5 beginning about two weeks after the ESI's. Tramadol was continued and Meloxicam discontinued. The patient was to follow up in the office 2-3 weeks after the procedures. There is no documented rationale for the ESI's or RFA's except that the patient is experiencing a return of her original pain. There is no description of the patient's functional status or of any functional goals. The requests for ESI's and RFA were non-certified in UR on 9/26/14. The request for a follow-up office visit in 2-3 weeks was apparently interpreted as a request for three office visits, of which only one was determined medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

TFESI L4-5, L5-S1 Directed Right: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management, and Criteria for the use of Epi. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UptoDate, an online, evidence-based review service for clinicians (www.uptodate.com), Subacute and chronic low back pain: Nonsurgical interventional treatment

Decision rationale: The MTUS guidelines cited above state that all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Epidural steroid injections (ESI's) alone offer no significant long-term functional benefit. The purpose of an ESI is to reduce pain and inflammation, and to restore range of motion in order to facilitate progress in more active treatment programs. Radiculopathy must be documented by physical exam and corroborated by imaging prior to performing an ESI. No more than one interlaminar level should be injected at one session, and no more than two nerve root levels should be injected using a transforaminal approach. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6-8 weeks. The Up-to-date citation states that the FDA issued a drug safety communication in 2014 regarding ESI's, noting the potential for rare but serious adverse effects including loss of vision, stroke, paralysis, and death; and also noting that ESI effectiveness has not been established. The clinical documentation in this case does not support the performance of lumbosacral ESI's. This patient's symptoms, which include limb pain relieved by leaning forward, and bowel and bladder incontinence, are suggestive of spinal stenosis or other serious spinal pathology. Serious spinal pathology would not be addressed by RFA, and should be evaluated prior to performing any procedure. There is no clear documentation of radicular findings. Pain radiation to one limb is not necessarily radicular unless it involves a dermatomal distribution. There is no documented imaging study which corroborates radiculopathy. There is no documentation of more than 50% pain relief with previous ESI's, and in fact the stated goal by the current provider is 30-40% reduction in pain, which is less than that which would warrant the procedure. This patient already has normal range of motion, and could participate in more active treatment programs, none of which are being recommended. There is no documentation of the patient's current functional level, or of any current functional goals. Based on the evidence-based citations above and on the clinical records provided for my review, transforaminal ESI's at L4-5, L5-S1, Directed Right are not medically necessary. They are not medically necessary because the patient does not have clear radiculopathy documented on physical exam and confirmed by imaging, because it is not clear that the patient had a sufficient response to previous ESI's to warrant further injections, because the patient does not appear to be participating in an active treatment program, and because there is no documented functional

status or functional goals. In addition there is concern about potentially serious side effects and lack of efficacy of ESI's according to the FDA, and there is no documentation of a rationale for their performance in this case that is strong enough to override these concerns. As such, the request is deemed not medically necessary.

Bilateral RFA's L2, L3, L4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Facet Joint Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Functional Restoration Approach to Chronic Pain Manag. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM Updated Back Chapter, Revised 2007, page 109

Decision rationale: Radiofrequency ablation (RFA) is also known as radiofrequency neurotomy. The MTUS guidelines cited above state that all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. The ACOEM reference cited above states that radiofrequency neurotomy, neurotomy, and facet rhizotomy are not recommended for the treatment of any spinal condition. To date, no procedure that involves cutting or ablating nerve fibers has been shown to be effective for the treatment of pain. Radiofrequency lesioning is invasive, has adverse effects, and is costly. The clinical documentation does not support the performance of RFA in this case. Many of the same concerns apply that apply to the performance of ESI's. The patient's symptoms suggest the possibility of serious spinal pathology that would not be addressed by RFA, and that should be evaluated prior to performing any procedure. The provider does not make clear what he believes is the source of the patient's pain. Facet-generated pain does not improve with treatment for radiculopathy (i.e. ESI), which he is also recommending. The provider states that the patient's symptoms improved by 80% with prior RFA, but there is no accompanying documentation of this result and in particular no documentation of functional recovery as a result of RFA. There are no current documented functional statuses or functional goals for this patient. Finally, there is no documentation of a compelling reason to perform a procedure that is not recommended by ACOEM, that has not been shown to be efficacious, and carries significant risks. The request is considered not medically necessary.

Follow-Up Office Visits X 3: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Pain Chapter- Office Visits

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Office Visits

Decision rationale: The ODG reference cited above states that evaluation and management outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office is based on a number of individualized determinations which include the patient's concerns, signs and symptoms, clinical stability, and medications. The clinical documentation in this case supports continuing office visits. This patient has apparently developed increased pain after a hiatus, and has symptoms that may be indicative of serious spinal pathology. She is taking Tramadol, which is an opioid. All of these issues warrant continued periodic office visits, and allowing for only one office visit is unnecessarily restrictive. Based on the evidence-based guideline cited above and on the clinical documentation provided for my review, at least three office visits ARE medically necessary in this case, because the patient has newly increased pain, symptoms that may represent serious spinal pathology, and she is taking a medication which requires monitoring.