

Case Number:	CM14-0030447		
Date Assigned:	06/20/2014	Date of Injury:	03/23/2004
Decision Date:	09/12/2014	UR Denial Date:	02/28/2014
Priority:	Standard	Application Received:	03/10/2014

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 & Rehabilitation and is licensed to practice in Texas and Oklahoma. 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 52-year-old female who reported an injury on 03/23/2014 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to her low back. The injured worker's treatment history included medications, activity modifications, corticosteroid injections, epidural steroid injections, and physical therapy. The injured worker was evaluated on 01/09/2014. It was noted that the injured worker had continued low back pain rated at a 7/10 that increased to a 10/10 with rotational movements. The injured worker's medications included Vicodin 5/500 mg, votaren gel 1%, and Voltaren extended release 100 mg. Pfs included tenderness to palpation of the lumbar paraspinal musculature with a positive left-sided straight leg raising test. The injured worker's diagnoses included significant disc collapse from the L2-3 and L3-4, severe disc collapse at the L5-S1 with retrolisthesis of the L5 on the S1, moderate left L5 foraminal stenosis, moderate to severe left L4-5 lateral recess and foraminal stenosis, left L5 radiculopathy, and multilevel degenerative disc disease of the lumbar spine. The injured worker's treatment plan included medial branch block to determine the appropriateness of a radiofrequency ablation. A request was made for an L3-S1 facet block with [REDACTED], possible radiofrequency ablation if facet blocks are diagnostic, diagnostic discogram from the L2-S1 if facet are nondiagnostic, a Medrol Dosepak, Voltaren gel. A Request for Authorization form was not submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-S1 Facet Blocks With [REDACTED]: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Facet Injections (diagnostic).

Decision rationale: The requested L3-S1 facet blocks are not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommend radiofrequency ablation be performed after an appropriate response to diagnostic facet injections. Official Disability Guidelines further clarify that medial branch blocks are appropriate for injured workers in the absence of radiculopathy and in the presence of well documented facet mediated pain that has failed to respond to conservative treatment. The clinical documentation submitted for review does indicate that the injured worker has radiculopathy. Additionally, Official Disability Guidelines do not recommend facet injections at more than 2 levels. The request includes 4 levels of treatment. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. As such, the requested L3-S1 facet blocks with [REDACTED] are not medically necessary or appropriate.

Possible Radiofrequency Ablation If Facet Blocks Are Diagnostic: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Diagnostic Discogram At L2-S1 If Facet Blocks Are Non-Diagnostic: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

Decision rationale: The request for Medrol Dosepak is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine do not support the use of oral corticosteroids in the management of low back pain. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Furthermore, the request at it is submitted does not clearly identify a dosage, quantity, or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Medrol Dosepak is not medically necessary or appropriate.

Medrol Dose Pack: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://dailymed.nlm.nih.gov/dailymed/lookup.cfm>.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

Decision rationale: The request for Medrol Dosepak is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine do not support the use of oral corticosteroids in the management of low back pain. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Furthermore, the request at it is submitted does not clearly identify a dosage, quantity, or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Medrol Dosepak is not medically necessary or appropriate.

Voltaren GEL 1% Quantity Three Tubes: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The requested Voltaren gel 1% quantity 3 tubes is not medically necessary or appropriate. The clinical documentation supports that the injured worker has been using this medication for an extended duration of time. California Medical Treatment Utilization Schedule does not support the use of Voltaren gel for spine related pain. Additionally, California MTUS recommends the use of this medication as a topical analgesic be limited to 4 weeks. The clinical documentation does indicate that the injured worker has been on this medication for an extended duration of time. Therefore, continued use would not be supported. Additionally, the request as it is submitted does not clearly identify a frequency of treatment or an applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Voltaren gel 1% quantity 3 tubes is not medically necessary or appropriate.