

Case Number:	CM14-0030972		
Date Assigned:	06/20/2014	Date of Injury:	05/30/2012
Decision Date:	07/21/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	03/11/2014

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 is licensed to practice in Texas. 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 patient is a 65-year-old female injured on 5/30/12 due to an undisclosed mechanism of injury. Current diagnoses include lumbar spinal stenosis, sacroiliitis, lumbosacral neuritis, long-term medication use, enthesopathy of the hip, lumbosacral spondylosis, and lumbar disc degeneration. Clinical note dated 02/17/14 indicates the patient presented complaining of left low back pain and left leg pain which has progressively worsened over time. Patient reported inability to stand straight due to increased pain. Clinical note also noted previous radiofrequency procedure helped with pain levels. Patient rated pain at 6/10. Physical examination revealed tenderness on palpation to left L3/4, 4/5, 5/S1 facet joints, painful range of motion on extension, negative iliac compression and posterior sacral compression tests, and positive facet joint/neuroforaminal loading test on the left. Additional exam findings include motor weakness left greater than right, reduced sensation left anterior/medial ankle to pinprick and light touch, reflexes 2 + right quadriceps, 1 + left quadriceps, 1 + right gastroc, trace left gastroc, and antalgic gait. MRI of the lumbar spine performed on 7/2/12 revealed multilevel degenerative disc disease and spondylosis, severe degenerative disc disease thoracolumbar junction and lower lumbar zygapophyseal joint osteoarthritis, and no significant lumbar spinal stenosis. Medications include Percocet 10 -325 mg Q8 hours, Tramadol 50 mg Q6 hours, and Etodolac 400 mg bid. The initial request for Tramadol 50 mg quantity 120, left L3 radiofrequency neurotomy with sedation under fluoroscopy quantity two, left L4 radiofrequency neurotomy with sedation under fluoroscopy quantity two, and left L5 radiofrequency neurotomy with sedation under fluoroscopy quantity two was initially non-certified on 2/27/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg quantity 120.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: Patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity for the request cannot be established at this time. Therefore, the request for Tramaodol 50 mg quantity 120 is not medically necessary and appropraite.

Left L3 radio frequency neurotomy with sedation under fluoroscopy quantity 2.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low back pain, Facet joint radiofrequency neurotomy.

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, repeat neurotomies should not occur at an interval of less than 6 months from the first procedure unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. The procedure is not 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. Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in visual analog scale (VAS) score, decreased medications and documented improvement in function and no more than two joint levels are to be performed at one time. In this case, the records indicated the patient underwent prior radio frequency neurotomy but the date, level at which it was performed, and extent of pain relief achieved was not provided for review. The request for left L3 radio frequency neurotomy with sedation under fluoroscopy quantity 2 is not medically necessary and appropriate.

Left L4 radio frequency neurotomy with sedation under fluoroscopy quantity 2.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low back pain, Facet joint radiofrequency neurotomy.

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, repeat neurotomies should not occur at an interval of less than 6 months from the first procedure unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. The procedure is not 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. Approval of repeat neurotomies depends on evidence of adequate diagnostic blocks, documented improvement in visual analog scale score, decreased medications and documented improvement in function. No more than two joint levels are to be performed at one time. Therefore, the request for Left L4 radio frequency neurotomy with sedation under fluoroscopy quantity 2 is not medically necessary and appropriate.

Left L5 radio frequency neurotomy with sedation under fluoroscopy quantity 2.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low back pain, Facet joint radiofrequency neurotomy.

Decision rationale: Repeat neurotomies should not occur at an interval less than 6 months from the first procedure unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. The procedure is not 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. Approval of repeat neurotomies depends on evidence of adequate diagnostic blocks, documented improvement in visual analog scale score, decreased medications and documented improvement in function. No more than two joint levels are to be performed at one time. In this case, the records indicated the patient underwent prior radio frequency neurotomy but the date, level, and extent of pain relief achieved was not provided for review. Therefore, the request for Left L5 radio frequency neurotomy with sedation under fluoroscopy quantity 2.00 is not medically necessary and appropriate.