MAXIMUS Federal Services

Case Number:	CM14-0055538		
Date Assigned:	07/09/2014	Date of Injury:	01/16/2006
Decision Date:	08/07/2014	UR Denial Date:	04/17/2014
Priority:	Standard	Application Received:	04/24/2014

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, has a subspecialty in Pain Management 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 is a female patient with the date of injury of January 16, 2006. A Utilization Review was performed on April 17, 2014 and recommended non-certification for 1 repeat radiofrequency (RF) ablation including bilateral medial branch nerves at L3/4 and bilateral dorsal ramus branch at L5, 1 prescription of Fetzima 20mg #30, and 1 prescription of Ibuprofen 800mg #90. A Progress Report dated April 7, 2014 identifies back stiffness and shoulder pain. The patient has had 5 ablation procedures on 11/17/2008, 9/28/2009, 3/31/2010, 10/27/2010, and 4/18/2012. The patient has received at least 70% relief from each of those ablation procedures and was able to decrease his intake on Norco. Physical Examination identifies pain to palpation over the L3 to L4, L4 to L5, and L5 to S1 facet capsules bilateral, pain with rotational extension, and secondary myofascial pain with triggering, ropey fibrotic banding and spasm bilateral. Impression identifies right wrist interarticular injury with likely carpal tunnel syndrome, chronic cervical, lumbar spine pain likely with mixed discogenic and fact mediated compromise and possibly SI joint injury. The plan identifies requested medications for one month and repeat RF ablation bilateral medial branch nerves L3/L4 and the bilateral dorsal ramus branch at L5.

IMR ISSUES, DECISIONS AND RATIONALES

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

One repeat radiofrequency (RF) ablation including bilateral medical branch nerves at L3/4: 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-Lumbar & Thoracic (Acute & chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back Page(s): 300, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Facet Joint Pain, Signs & Symptoms, Facet Joint Diagnostic Blocks (Injections), Facet Joint Radiofrequency Neurotomy.

Decision rationale: Regarding the request for one repeat radiofrequency (RF) ablation including bilateral medical branch nerves at L3/4, Chronic Pain Medical Treatment Guidelines state there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. ODG states the Criteria for the use of diagnostic blocks for facet mediated pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. ODG further recommends the following Criteria for use of facet joint radiofrequency neurotomy: (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. Repeat neurotomies should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function. Within the medical information made available for review, there is mention that the patient underwent previous rhizotomy with at least 70% pain relief and reduction in medication use. However, there is no indication that duration of relief was at least 12 weeks. There is no mention of documented improvement in function. In the absence of such documentation, the current request for one repeat radiofrequency (RF) ablation including bilateral medical branch nerves at L3/4 is not medically necessary.

One repeat radiofrequency (RF) ablation including bilateral dorsal ramus branch at L5: 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-Lumbar & Thoracic (Acute & chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back Page(s): 300, 309. Decision based on Non-MTUS Citation Official Disability Guidelines

(ODG), Low Back Chapter, Facet Joint Pain, Signs & Symptoms, Facet Joint Diagnostic Blocks (Injections), Facet Joint Radiofrequency Neurotomy.

Decision rationale: Regarding the request for one repeat radiofrequency (RF) ablation including bilateral dorsal ramus branch at L5, Chronic Pain Medical Treatment Guidelines state there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. ODG states the Criteria for the use of diagnostic blocks for facet mediated pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. ODG further recommends the following Criteria for use of facet joint radiofrequency neurotomy: (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. Repeat neurotomies should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function. Within the medical information made available for review, there is mention that the patient underwent previous rhizotomy with at least 70% pain relief and reduction in medication use. However, there is no indication that duration of relief was at least 12 weeks. There is no mention of documented improvement in function. In the absence of such documentation, the current request for one repeat radiofrequency (RF) ablation including bilateral dorsal ramus branch at L5 is not medically necessary.

Fetzima 20 mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-16.

Decision rationale: Regarding the request for Fetzima, guidelines state that antidepressants are recommended as a 1st line option for neuropathic pain and as a possibility for non-neuropathic pain. Guidelines go on to recommend a trial of at least 4 weeks. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Within the documentation available for review, there is no identification that the Fetzima provides any specific analgesic effect (in terms of reduced numeric rating scale or percent reduction in pain), or provides any objective functional improvement, reduction in opiate

medication use, or improvement in psychological well-being, if it is being prescribed to treat depression. Additionally, if the Fetzima is being prescribed to treat depression, there is no documentation of depression, and no objective findings which would support such a diagnosis (such as a mini mental status exam, or even depressed mood). In the absence of clarity regarding those issues, the currently requested Fetzima is not medically necessary.

Ibuprofen 800 mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

Decision rationale: Regarding the request for Ibuprofen, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Ibuprofen is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Ibuprofen is not medically necessary.