MAXIMUS Federal Services

Case Number:	CM14-0097530		
Date Assigned:	07/23/2014	Date of Injury:	12/10/2008
Decision Date:	08/29/2014	UR Denial Date:	06/03/2014
Priority:	Standard	Application Received:	06/12/2014

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 Occupational 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 patient is a 43 year old female who was injured on 12/10/2008. The mechanism of injury is unknown. Prior treatment history has included intramuscular injection. Prior medication history included Topamax, Robaxin 750 mg, phenergan, Demerol, Exalgo, Dilaudid, Prilosec, Lidoderm 5%; and Subsys.Diagnostic studies reviewed include computed tomography (CT) of the lumbar spine dated 03/21/2014 demonstrated fusion from L4 through S1 appears satisfactory; lordotic exaggeration is moderate from L4 through S1, unchanged; facet joint ankylosis at L4-L5 bilaterally has progressed; no frank disc extrusion. On note dated 05/21/2014, the patient presented with chronic pain syndrome from the lumbar and cervical spine injury. She reported she is unable to perform activities of daily living due to the pain. Objective findings on exam revealed decreased range of motion to flexion and extensio. She has severe tenderness down the posterior columns into the trapezius. There is mild myofasciitis in the trapezius muscles to the shoulders as well as scapula. The lumbar spine revealed decreased range of motion and increased muscle spasm. She has moderate to severe tenderness diffusely from the high lumbar area down to the sacrum secondary to myofasciitis and muscle spasm. She has tenderness over the left paraspinous area at L4-5. There was moderate sacroilitis and pain over the sacroiliac (SI) joints bilaterally. She has pain with facet manuevers with extension a nd lateral rotation bilaterally, left greater than right. Straight leg raise is positive on the left. The patient is diagnosed with lumbar disc herniation with radiculopathy, status post lumbar spine surgery, with continued severe pain; possible painful hardware, including spinal stimulator leads; and myofasciitis with deconditioning and spasm of the lumbar spine; sacroilitis; and severe cervicogenic headaches. The patient has been recommended for radiofrequency ablation of the lumbar facet nerves as well as facet injections at levels L4-L5 and L5-S1. She was also recommended for formal detoxification program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Radiofrequency ablation lumbar facet L4-5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar & Thoracic, (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Facet Joint Radiofrequency Neurotomy.

Decision rationale: According to MTUS guidelines, lumbar radiofrequency ablation is under study. Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis (only 3 Randomized Controlled Trials (RCTs) with one suggesting pain benefit without functional gains, potential benefit if used to reduce narcotics). Studies have not demonstrated improved function. Treatment requires a diagnosis of facet joint pain using a medial branch block. This is a request for L4-S1 radiofrequency ablation for a 35-year-old female with chronic neck and low back pain, failed back surgery, and depression injured on 12/10/08 status post lumbar fusion from L4-S1. However, efficacy of this procedure is questionable. Further, diagnostic facet joint injections, required for a radiofrequency ablation procedure, are not recommended in the setting of prior lumbar fusion surgery. Medical necessity is not established.

Facet injection L4-5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar & Thoracic, (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) : Low Back, Facet joint Intraarticular Injections (Therapeutic Blocks), Facet Joint Diagnostic Blocks (Injections).

Decision rationale: According to MTUS guidelines, facet joint therapeutic injections are under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. There should not have been a previous lumbar fusion. There should be evidence of a formal plan of additional evidence-based activity and exercise. With regard to diagnostic facet joint blocks, they should not be performed in patients who have had a previous fusion procedure at the planned injection level. This is a request for L4-S1 facet injection for a 35-year-old female with chronic neck and low back pain, failed back surgery, and depression injured on 12/10/08 status post lumbar fusion from L4-S1. It appears that the injections are for therapeutic purposes though the intent is not specified in the record. In any case, neither diagnostic nor therapeutic facet joint injections are recommended in the setting

of prior lumbar fusion. There is no evidence of a formal plan of additional evidence-based activity and exercise. Medical necessity is not established.

Robaxin 750mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain, Methocarbamol (Robaxin).

Decision rationale: According to MTUS guidelines, muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain (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 non-steroidal anti-inflammatory drugs (NSAIDs) in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. In this case the patient is prescribed Robaxin on a long-term basis for chronic pain including low back pain. However, long-term use is not recommended. History and examination findings do not demonstrate clinically significant functional improvement, pain reduction or improved quality of life from use of this medication. Medical necessity is not established.