

Case Number:	CM15-0169242		
Date Assigned:	09/09/2015	Date of Injury:	01/23/2008
Decision Date:	10/27/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	08/27/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 50 year old female, who sustained an industrial injury on 1-23-08. She reported low back pain. The injured worker was diagnosed as having sacroiliitis, sacroiliac pain, lumbar facet syndrome, and low back pain. Treatment to date has included sacral medial branch radiofrequency neurotomy, sacral medial branch blocks, a sacroiliac joint steroid injection, physical therapy, and medication. On 6-12-15 pain was rated as 4 of 10 with medication and 7 of 10 without medication. On 8-7-15 pain was rated as 5 of 10 with medication and 9 of 10 without medication. The injured worker had been taking Roxicodone since at least January 2015 and MS Contin since at least May 2015. Physical examination findings on 8-7-15 included restricted lumbar range of motion due to pain. Paravertebral muscle spasms, tenderness to palpation, and tenderness over the right lumbar paravertebral muscles at L3-4 were also noted. Currently, the injured worker complains of low back pain. On 8-7-15 the treating physician requested authorization for right and left radiofrequency ablation at L4-5, right and left radiofrequency ablation at L5-S1, Roxicodone 15mg #90 with 1 refill, and MS Contin 30mg #60 with 1 refill. On 8-24-15 the request for radiofrequency ablation was non-certified; the utilization review physician noted "the available clinical information does not document positive diagnostic medial branch block at L4 and L5 bilaterally." Regarding the requested medications the utilization review physician modified the request to exclude refills and noted "refills do not allow for documentation of ongoing functional benefit and close monitoring."

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L4-L5 radiofrequency ablation Qty: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Lumbar & Thoracic (Acute & Chronic) - Facet joint diagnostic blocks (injections).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Radiofrequency Ablation, Lumbar Spine.

Decision rationale: California MTUS and ACOEM do not specifically address radiofrequency ablation. The Official Disability Guidelines indicate that facet joint radiofrequency neurotomy treatments typically require a diagnosis of facet joint pain using a medial branch block with initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks. It states that the procedure should not occur at an interval less than six months from the first procedure, and the first procedure should document improvement for at least twelve weeks at greater than 50% reduction of pain and that the procedure should not be repeated unless there is sustained pain relief, generally of at least six months duration. Approval of repeat neurotomies depend on documentation of visual analog pain scale scores, decreased medication usage, and documented improvement in function. Within the submitted records, there is insufficient documentation to support the requested procedure, based on the above criteria. There is no mention of positive response to a diagnostic block at the requested levels. As such, this request is non-certified and therefore is not medically necessary.

Left L4-L5 radiofrequency ablation Qty: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Lumbar & Thoracic (Acute & Chronic) - Facet joint diagnostic blocks (injections).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Radiofrequency Ablation, Lumbar Spine.

Decision rationale: California MTUS and ACOEM do not specifically address radiofrequency ablation. The Official Disability Guidelines indicate that facet joint radiofrequency neurotomy treatments typically require a diagnosis of facet joint pain using a medial branch block with initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks. It states that the procedure should not occur at an interval less than six months from the first procedure, and the first procedure should document improvement for at least twelve weeks at greater than 50% reduction of pain and that the procedure should not be repeated unless there is sustained pain relief, generally of at least six months duration. Approval of repeat neurotomies depend on documentation of visual analog pain scale scores, decreased medication usage, and documented improvement in function. Within the submitted records, there is insufficient documentation to support the requested procedure, based on the above criteria. There is no mention of positive response to a diagnostic block at the requested levels. As such, this request is non-certified and therefore is not medically necessary.

Right L5-S1 radiofrequency ablation Qty: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Lumbar & Thoracic (Acute & Chronic) - Facet joint diagnostic blocks (injections).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Radiofrequency Ablation, Lumbar Spine.

Decision rationale: California MTUS and ACOEM do not specifically address radiofrequency ablation. The Official Disability Guidelines indicate that facet joint radiofrequency neurotomy treatments typically require a diagnosis of facet joint pain using a medial branch block with initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks. It states that the procedure should not occur at an interval less than six months from the first procedure, and the first procedure should document improvement for at least twelve weeks at greater than 50% reduction of pain and that the procedure should not be repeated unless there is sustained pain relief, generally of at least six months duration. Approval of repeat neurotomies depend on documentation of visual analog pain scale scores, decreased medication usage, and documented improvement in function. Within the submitted records, there is insufficient documentation to support the requested procedure, based on the above criteria. There is no mention of positive response to a diagnostic block at the requested levels. As such, this request is non-certified and therefore is not medically necessary.

Left L5-S1 radiofrequency ablation Qty: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Lumbar & Thoracic (Acute & Chronic) - Facet joint diagnostic blocks (injections).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Radiofrequency Ablation, Lumbar Spine.

Decision rationale: California MTUS and ACOEM do not specifically address radiofrequency ablation. The Official Disability Guidelines indicate that facet joint radiofrequency neurotomy treatments typically require a diagnosis of facet joint pain using a medial branch block with initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks. It states that the procedure should not occur at an interval less than six months from the first procedure, and the first procedure should document improvement for at least twelve weeks at greater than 50% reduction of pain and that the procedure should not be repeated unless there is sustained pain relief, generally of at least six months duration. Approval of repeat neurotomies depend on documentation of visual analog pain scale scores, decreased medication usage, and documented improvement in function. Within the submitted records, there is insufficient documentation to support the requested procedure, based on the above criteria. There is no mention of positive response to a diagnostic block at the requested levels. As such, this request is non-certified and therefore is not medically necessary.

Roxicodone tablets 15mg tablets (#90 with 1 refill) 3 times daily as needed Qty: 180.00:
Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: The California MTUS guidelines allows for the use of opioid medication, such as Roxicodone, for the management of chronic pain and outlines clearly the documentation that would support the need for ongoing use of an opioid. These steps include documenting pain and functional improvement using validated measures at 6 months intervals, documenting the presence or absence of any adverse effects, documenting the efficacy of any other treatments and of any other medications used in pain treatment. The submitted documentation supports the request for ongoing opioid use. The injured worker has significant pain reduction, increased activity levels, better quality of sleep, and there are no adverse side effects noted, nor is there aberrant drug taking behavior. This request is certified and therefore is medically necessary.

MS Contin tablet 30mg tablets (#60 with 1 refill) twice daily Qty: 120.00: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: The California MTUS guidelines allows for the use of opioid medication, such as MS Contin, for the management of chronic pain and outlines clearly the documentation that would support the need for ongoing use of an opioid. These steps include documenting pain and functional improvement using validated measures at 6 months intervals, documenting the presence or absence of any adverse effects, documenting the efficacy of any other treatments and of any other medications used in pain treatment. The submitted documentation supports the request for ongoing opioid use. The injured worker has significant pain reduction, increased activity levels, better quality of sleep, and there are no adverse side effects noted, nor is there aberrant drug taking behavior. This request is certified and therefore is medically necessary.