

Case Number:	CM15-0022747		
Date Assigned:	02/12/2015	Date of Injury:	07/19/1988
Decision Date:	03/25/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/06/2015

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
 Certification(s)/Specialty: Emergency Medicine

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 55 year old male who sustained an industrial related injury on 7/19/88. The injured worker had complaints of back pain with spasm and weakness. Left lower extremity pain was also noted. The diagnosis was lumbar sprain with disk herniation status post two level lumbar fusion at L3-4 and L4-5. Treatment included a left L2 transforaminal epidural steroid injection on 5/9/14. Medication included Orphenadrine and Dilaudid. The treating physician requested authorization for a right L5 transforaminal epidural steroid injection and bilateral L2-3 radiofrequency ablation. On 1/26/15 the requests were non-certified. Regarding the epidural steroid injection, the utilization review (UR) physician cited the Medical Treatment Utilization Schedule (MTUS) guidelines and noted there was no evidence the injured worker had functional improvement and reduction in medication use due to prior epidural steroid injections. Therefore the request was non-certified. Regarding radiofrequency ablation, the UR physician cited the MTUS guidelines and Official Disability Guidelines. The UR physician noted there was no evidence the injured worker had functional improvement or reduction in medication use from the previous radiofrequency ablation procedure. Therefore the request was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L5 Transforaminal Epidural Steroid Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines - Pain, Epidural Steroid Injections

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: The requested Right L5 Transforaminal Epidural Steroid Injection is not medically necessary. California's Division of Worker's Compensation Medical Treatment Utilization Schedule (MTUS), Chronic Pain Medical Treatment Guidelines, Pg. 46, Epidural steroid injections (ESIs), recommend an epidural injection with documentation of persistent radicular pain and physical exam and diagnostic study confirmation of radiculopathy, after failed therapy trials; and note in regard to repeat injections: "In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year." The injured worker back pain with spasm and weakness. The treating physician has not documented the percentage or duration of functional improvement from a previous procedure. The criteria noted above not having been met, Right L5 Transforaminal Epidural Steroid Injection is not medically necessary.

Bilateral L2 and L3 Radio Frequency Ablation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/15875137>, <http://www.ncbi.nlm.nih.gov/pubmed/18295703>, Official Disability Guidelines - Low Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic)?(updated 07/03/14), Radio-Frequency Ablation

Decision rationale: The requested Bilateral L2 and L3 Radio Frequency Ablation, is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 12, Low Back Chapter, Pages 300-301, note that lumbar facet neurotomies produce mixed results and should be performed only after medial branch blocks. ODG -TWC, Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 07/03/14), Radio-Frequency Ablation, recommend facet neurotomies if successful diagnostic medical branch blocks (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive); No more than 2 joint levels may be blocked at any one time. Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function. The injured worker back pain with spasm and weakness. The treating physician has not documented the percentage or duration of functional improvement from a

previous procedure. The criteria noted above not having been met, Bilateral L2 and L3 Radio Frequency Ablation is not medically necessary.