

Case Number:	CM15-0049646		
Date Assigned:	03/23/2015	Date of Injury:	03/15/2002
Decision Date:	05/12/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/16/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 49-year-old male who reported an injury on 03/15/2002. The mechanism of injury was unspecified. His diagnoses include lumbar spondylosis without myelopathy, lumbar degenerative disc disease, back pain, lumbago and cervicgia. His past treatments include medications and radiofrequency ablations. An official lumbar MRI was performed on 12/12/2014, which revealed no disc bulge or protrusion with any evidence of significant central neural foraminal narrowing at the L2-3 and L3-4 levels. The injured worker underwent a previous radiofrequency ablation to the bilateral L2-3 and L3-4 on 10/14/2013. On 02/06/2015, the injured worker complained of back pain rated 6/10 located in the midline of the low back that radiated to the bilateral lower extremities. The physical examination of the lumbar spine revealed severe tenderness of the upper lumbar spine with moderately decreased range of motion. The injured worker had a negative faber test, negative straight leg raise, negative Waddell's and negative Kemp's test. The injured worker had a positive Kemp's test and facet loading test on the right. Strength, sensation and reflexes were indicated to be intact and within normal values. His current medications included lisinopril 10 mg, tetracycline 250 mg, Viagra 100 mg, Synthroid 100 mg, Nexium 40 mg, Valium 10 mg, ibuprofen 800 mg, amlodipine 5 mg and dexamethasone 0.5 mg. The treatment plan include Valium 10 mg and bilateral radiofrequency ablations to the L2-3 and L3-4 as the injured worker stated this is the procedure that has helped him the most out of all treatments in the past. A Request for Authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Valium 10mg qty: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24, 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: According to the California MTUS Guidelines benzodiazepines are not recommended for long term use due to unproven efficacy and the risk of dependence. Most guidelines limit the use to 4 weeks. The injured worker was noted to have been on Valium for an unspecified duration of time. However, there is lack of documentation clarifying the complete duration of use. Furthermore, the guidelines do not recommend the use of benzodiazepines. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary or appropriate at this time.

Left radiofrequency ablation at L2-3: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, Facet joint radiofrequency neurotomy.

Decision rationale: According to the California MTUS/ACOEM Guidelines, invasive techniques such as radiofrequency neurotomies do not have supporting literature indicating temporary relief of pain. Furthermore, they should perform only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. More specifically, the criteria for a facet joint radiofrequency neurotomy include: May be repeated with documentation that the previous injection provided at least 50% relief for 12 weeks with documented improvement in VAS scores, decreased medication usage and improvement in function. The injured worker was noted to have undergone previous bilateral medial radiofrequency ablation to the L2-3 and L3-4 on 10/14/2013. However, there was lack of documentation indicating the injured worker had at least 50% pain relief with documented improvement in VAS scores, decreased medication usage and improvement in function. In the absence of the above, a repeat radiofrequency ablation is not recommended or supported by the evidence based guidelines. As such, the request is not medically necessary or appointment at this time.

Right radiofrequency ablation at L2-3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG Low Back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, Facet joint radiofrequency neurotomy.

Decision rationale: According to the California MTUS/ACOEM Guidelines, invasive techniques such as radiofrequency neurotomies do not have supporting literature indicating temporary relief of pain. Furthermore, they should perform only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. More specifically, the criteria for a facet joint radiofrequency neurotomy include: May be repeated with documentation that the previous injection provided at least 50% relief for 12 weeks with documented improvement in VAS scores, decreased medication usage and improvement in function. The injured worker was noted to have undergone previous bilateral medial radiofrequency ablation to the L2-3 and L3-4 on 10/14/2013. However, there was lack of documentation indicating the injured worker had at least 50% pain relief with documented improvement in VAS scores, decreased medication usage and improvement in function. In the absence of the above, a repeat radiofrequency ablation is not recommended or supported by the evidence based guidelines. As such, the request is not medically necessary or appointment at this time.

Left radiofrequency ablation at L3-4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG Low Back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, Facet joint radiofrequency neurotomy.

Decision rationale: According to the California MTUS/ACOEM Guidelines, invasive techniques such as radiofrequency neurotomies do not have supporting literature indicating temporary relief of pain. Furthermore, they should perform only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. More specifically, the criteria for a facet joint radiofrequency neurotomy include: May be repeated with documentation that the previous injection provided at least 50% relief for 12 weeks with documented improvement in VAS scores, decreased medication usage and improvement in function. The injured worker was noted to have undergone previous bilateral medial radiofrequency ablation to the L2-3 and L3-4 on 10/14/2013. However, there was lack of documentation indicating the injured worker had at least 50% pain relief with documented improvement in VAS scores, decreased medication usage and improvement in function. In the absence of the above, a repeat radiofrequency ablation is not recommended or supported by the evidence based guidelines. As such, the request is not medically necessary or appointment at this time.

Right radiofrequency ablation at L3-4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG Low Back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, Facet joint radiofrequency neurotomy.

Decision rationale: According to the California MTUS/ACOEM Guidelines, invasive techniques such as radiofrequency neurotomies do not have supporting literature indicating temporary relief of pain. Furthermore, they should perform only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. More specifically, the criteria for a facet joint radiofrequency neurotomy include: May be repeated with documentation that the previous injection provided at least 50% relief for 12 weeks with documented improvement in VAS scores, decreased medication usage and improvement in function. The injured worker was noted to have undergone previous bilateral medial radiofrequency ablation to the L2-3 and L3-4 on 10/14/2013. However, there was lack of documentation indicating the injured worker had at least 50% pain relief with documented improvement in VAS scores, decreased medication usage and improvement in function. In the absence of the above, a repeat radiofrequency ablation is not recommended or supported by the evidence based guidelines. As such, the request is not medically necessary or appointment at this time.