MAXIMUS Federal Services

Case Number:	CM15-0058920		
Date Assigned:	04/16/2015	Date of Injury:	05/14/2008
Decision Date:	06/08/2015	UR Denial Date:	03/19/2015
Priority:	Standard	Application Received:	03/27/2015

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, 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 female, who sustained an industrial injury on May 14, 2008 due to a motor vehicle accident. She reported pain in her lower back, upper back, around the scapular area, and right trapezius. The injured worker was diagnosed as having lumbago and sacroilitis. Treatment to date has included MRIs, x-rays, electro diagnostic studies, urine drug screening, rest, physical therapy, home exercise program, chiropractic therapy, massage therapy, work modifications, trigger point injections, lumbar facet blocks, transforaminal epidural steroid injections, and medications including oral pain, topical pain, muscle relaxant, and non-steroidal anti-inflammatory. On March 11, 2015, the injured worker complains of constant, sharp, and aching upper back pain and aching low back pain. Associated symptoms include a burning sensation in her back. Her pain is 1/10 on average and 10/10 at the worst. Her pain improves with a transcutaneous electrical nerve stimulation (TENS) unit, topical compound pain medication, rest, and ice. The physical exam revealed positive bilateral Patrick's test, bilateral sacroiliac and sacroiliac joint tenderness, lumbar facet tenderness, worsened pain with axil loading of the lumbar spine, decreased range of motion due to pain, pain and tenderness on the right lumbar 4-5 and lumbar 5-sacral 1, right dermatome hyperalgesia , a normal motor exam, and normal reflexes of the lower extremities. The treatment plan includes a TENS unit being dispensed, topical pain and topical compound pain medications, and consents for sacroiliac joint injection under fluoroscopic guidance and intra-articular facet injections at lumbar 4-5 and lumbar 5-sacral 1 under fluoroscopic guidance followed by radiofrequency ablation (RFA).

IMR ISSUES, DECISIONS AND RATIONALES

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

Dispensed Medrox Patches Qty: 6.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylate, Topical Analgesic, Topical Capsaicin Page(s): 105, 111, 28. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Medrox Online Package Insert.

Decision rationale: The California Medical Treatment Utilization Schedule indicates that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Additionally it indicates that Topical Salicylates are approved for chronic pain. According to the Medrox package insert, Medrox is a topical analgesic containing Menthol 5.00% and 0.0375% Capsaicin and it is indicated for the temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness, and stiffness. The clinical documentation submitted for review failed to indicate the injured worker had a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation indicating the injured worker had exceptional factors to warrant non-adherence to guideline recommendations. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for dispensed Medrox patches qty: 6.00 is not medically necessary.

Diclofenac 5% Gabapentin 6% Cyclobenzaprine 2% Bupivacaine 1% and Lidocaine 240gm: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Topical Antiepileptic Medications, Bupivacaine, Diclofenac, Cyclobenzaprine Page(s): 111, 113, 55, 71, 41.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended diclofenac is indicated for

relief of osteoarthritis pain in joints that lend themselves to topical treatment. The guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Topical Antiepileptic medications are not recommended as there is no peer reviewed literature to support topical use. Bupivacaine has been recommended as an alternative to clonidine, however a search of FDA guidelines indicate that Bupivacaine is approved for injection. The addition of cyclobenzaprine to other agents is not recommended. They do not recommend the topical use of Cyclobenzaprine as a topical muscle relaxants as there is no evidence for use of any other muscle relaxant as a topical product. The clinical documentation submitted for review failed to provide documentation of a trial and failure of antidepressants and anticonvulsants. The request as submitted failed to indicate the frequency and the body part to be treated. Given the above, the request for diclofenac 5% gabapentin 6% cyclobenzaprine 2% bupivacaine 1% and lidocaine 240gm is not medically necessary.

Dispensed TENS Unit Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 116-117.

Decision rationale: The California Medical Treatment Utilization Schedule guideline indicate that a one month trial of a TENS unit is recommended if it is used as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there, must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. There was a lack of documentation indicating the injured worker would utilize the unit as an adjunct to a program of evidence based functional restoration for chronic pain. The documentation indicated the injured worker had a reduction in pain with the use of the unit. However, there was a lack of documentation of an objective decrease in pain and objective functional improvement. The request as submitted failed to indicate whether the unit was for rental or purchase. Given the above, the request for dispensed TENS unit qty: 1.00 is not medically necessary.

Left Sacroiliac Joint Injection under Fluoroscopic: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis, Sacroiliac Joint Blocks.

Decision rationale: The Official Disability Guidelines indicate that the criteria for the use of sacroiliac block injections include the History and Physical should suggest a diagnosis with documentation of at least 3 positive examination findings as listed, including cranial shear test, extension test, flamingo test, Fortin finger test, Gaenslen's test, Gillett's test, Patrick test, pelvic compression test, pelvic distraction test, pelvic rock test, resisted abduction test, sacroiliac shear test, standing flexion test, seated flexion test, or thigh thrust test. The diagnostic evaluation must first address any other possible pain generators. There should be documentation the injured worker has tried and failed at least 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercise, and medication management, and the blocks are performed under fluoroscopy. The clinical documentation submitted for review indicated the injured worker had a positive Patrick test and sacroiliac joint tenderness test. However, there was a lack of documentation of a third positive examination finding. Additionally, there was a lack of documentation that the injured worker had trialed and failed at least 4 to 6 weeks of aggressive conservative therapy, including physical therapy, home exercise, and medication management. Given the above, the request for left sacroiliac joint injection under fluoroscopic is not medically necessary.

Left L4-5 Intra Articular Facet Joint Injection under fluoroscopic guidance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 (ODG) Low Back Chapter, Facet joint diagnostic blocks (injections) Facet joint medial branch blocks (therapeutic injections), Facet Joint Pain, Signs & Symptoms.

Decision rationale: The American College of Occupational and Environmental Medicine Guidelines indicate that a facet neurotomy (Rhizotomy) should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As the American College of Occupational and Environmental Medicine does not address specific criteria for medial branch diagnostic blocks, secondary guidelines were sought. The Official Disability Guidelines indicate that a medial branch block is not recommended except as a diagnostic tool. Minimal evidence for treatment. The clinical documentation submitted for review indicated the injured worker had previously undergone facet blocks. There was a lack of documentation indicating exceptional factors as this treatment is recommended only as a diagnostic tool and is not recommended for continued injections. Given the above, the request for left L4-5 intra articular facet joint injection under fluoroscopic guidance is not medically necessary.

Left L5-S1 Intra Articular Facet Joint Injection under fluoroscopic guidance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 (ODG) Low Back Chapter, Facet joint diagnostic blocks (injections) Facet joint medial branch blocks (therapeutic injections), Facet Joint Pain, Signs & Symptoms.

Decision rationale: The American College of Occupational and Environmental Medicine Guidelines indicate that a facet neurotomy (Rhizotomy) should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As the American College of Occupational and Environmental Medicine does not address specific criteria for medial branch diagnostic blocks, secondary guidelines were sought. The Official Disability Guidelines indicate that a medial branch block is not recommended except as a diagnostic tool. Minimal evidence for treatment. The clinical documentation submitted for review indicated the injured worker had previously undergone facet blocks. There was a lack of documentation indicating exceptional factors as this treatment is recommended only as a diagnostic tool and is not recommended for continued injections. Given the above, the request left L5-S1 intra articular facet joint injection under fluoroscopic guidance is not medically necessary.

Left L4-5 radiofrequency ablation Qty: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

Decision rationale: The American College of Occupational and Environmental Medicine guidelines indicate that radiofrequency neurotomy for the treatment of select patients with low back pain is recommended as 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. The physician documentation indicated that the injured worker would have an injection followed by a radiofrequency ablation. Without documented objective pain relief per the VAS scale and objective functional improvement, this request would not be supported. There was a lack of documentation of exceptional factors. Given the above, the request for Left L4-5 radiofrequency ablation qty: 1.00 is not medically necessary. Given the above, the request for left L4-5 radiofrequency ablation qty: 1.00 is not medically necessary.

Left L5-S1 Radiofrequency Ablation Qty: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

Decision rationale: The American College of Occupational and Environmental Medicine guidelines indicate that radiofrequency neurotomy for the treatment of select patients with low back pain is recommended as 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. The physician documentation indicated that the injured worker would have an injection followed by a radiofrequency ablation. Without documented objective pain relief per the VAS scale and objective functional improvement, this request would not be supported. There was a lack of documentation of exceptional factors. Given the above, the request for Left L4-5 radiofrequency ablation qty: 1.00 is not medically necessary. Given the above, the request for left L5-S1 radiofrequency ablation qty: 1.00 is not medically necessary.