

Case Number:	CM15-0121132		
Date Assigned:	07/01/2015	Date of Injury:	02/02/1992
Decision Date:	08/04/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/23/2015

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 48 year old female who sustained an industrial injury on 2/2/92 with a current chief complaint of low back pain. Diagnoses are trochanteric bursitis, low back pain, spondylosis of lumbosacral joint without myelopathy, and failed back surgery syndrome status post 7 lumbar surgeries. In a progress report dated 5/8/15, the treating physician notes mainly axial pain with minimal radicular complaints. Failed conservative therapy includes non-steroidal anti-inflammatory medication, Tylenol, physical therapy, and home exercise program. Exam/history is negative for radiculopathy and concordant for facetogenic pain. She had a significant positive response of over 70-90% relief lasting over 2hours with comparative, diagnostic medial branch block/facet joint injection. Based on this, will request radiofrequency ablation for long-term relief of pain symptoms. Since being taken off the Norco, her pain has been severely exacerbated and she notes improved function only while taking the medication. She is unable to function with intense pain levels and it is necessary for improved function as it provides over 70% pain relief. Medications noted are Norco, Neurontin, Tizanidine Hydrochloride, and Kadian. Physical exam reveals lumbar spine range of motion is moderately limited with extension and rotation, is painful and there is tenderness to palpation in bilateral paraspinal muscles, and painful facet loading bilaterally. Straight leg raise is negative. Her gait is antalgic. There is tenderness to palpation of the left trochanter and iliotibial band and gluteal tendon. Previous treatment includes seven lumbar surgeries, spinal cord stimulator, trochanteric bursa injections, medial branch blocks, therapy, Neurontin, Tizanidine Hydrochloride, Norco,

Kadian. The requested treatment is two right and left radiofrequency ablations L3, L4, L5, Norco 5/325 mg #120, and Tizanidine 4mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 Right and Left Radiofrequency Ablations L3, L4, L5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-1.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-302. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar and Thoracic, Facet joint radio frequency neurotomy.

Decision rationale: MTUS Chronic pain and ACOEM Guidelines do have any sections that properly relate to this topic. ACOEM only has general recommendation. Official Disability Guidelines were used for detailed criteria. As per Official Disability Guidelines basic criteria for recommendation of radio frequency ablation is a successful diagnostic facet block. A successful block requires objective documentation of improvement of at least 70% in pain lasting at least 2hours. The procedure note dated 12/11/14 fails to provide any documented objective relief and there is no documented pain assessment prior to procedure and no documentation of any pain assessment after procedure. There is also note stating that the procedure was done under monitored anesthesia which raises concerns about validity of any improvement since a valid block cannot be biased by any sedatives or any opioid pain medications received at home or during procedure. Anesthesia note dated 12/11/14 definitively invalidated the procedure by documenting that patient received 2 doses of propofol, an anesthetic, and fentanyl, an opioid, during the procedure. The primary provider then documented improvement as 70-90% lasting 2-4hours in a progress note a month after the provided procedure note. The documentation of facet block fails to support criteria for radio frequency ablation. There facet block findings are invalid and there is no clear objective improvement in pain or function after the block with no actual documentation of pain improvement after the procedure documented. Documentation fails to support medical necessity of Lumbar radio frequency ablation. Lumbar radio frequency ablation is not medically necessary.

1 prescription of Norco 5/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-79.

Decision rationale: Norco is acetaminophen and hydrocodone, an opioid. Patient has chronically been on an opioid pain medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation fails criteria. Provider has

failed to document any objective improvement in pain and function as required by MTUS guidelines. There is no visual analogue scale documented and there is no documentation of objective improvement in function. There is only subjective and vague description of improvement in pain and function provided in documentation. There is no long-term plan for opioid therapy with patient. Norco is not medically necessary.

1 prescription of Tizanidine 4mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-spasticity/anti-spasmodics Page(s): 60.

Decision rationale: Zanaflex (Tizanidine) is an antispasmodic muscle relaxant. It is FDA approved for muscle spasms. As per MTUS guidelines, muscle relaxants should be used for short-term use and for flare-ups only. There is no documentation of muscle spasms. Patient has been on this medication chronically and the number of tablets requested is not appropriate and not consistent with short-term use. Tizanidine is not medically necessary.