

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 physician 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/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The underlying date of injury in this case is 05/25/2010. The patient's primary treating diagnoses include lumbosacral spondylosis and lumbago. The patient is a 50-year-old man with a history of lumbar surgery and recent physical presentation with back pain and some symptoms to his thighs including numbness and tingling into both thighs and occasionally to the knees.

An initial physician review noted that the purpose of the pain management consultation was to provide requested bilateral facet injections and rhizotomy. This reviewer concluded that the treatment requests were not supported by the guidelines.

IMR DECISION(S) AND RATIONALE(S)

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

1. Referral to Pain Management Specialist, [REDACTED] M.D. is medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM guidelines and Official Disability Guidelines.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition (2004), Chapter 7, page 127.

The Physician Reviewer's decision rationale:

The California Medical Treatment Utilization Schedule does not directly address consultations. ACOEM Guidelines, Chapter 7 Consultation, page 127, states, "The occupational health

practitioner may refer to other specialists if the diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise.” An initial reviewer indicated that the request for a pain management consultation was solely for the purpose of invasive procedures. It is not apparent from the medical records that this was the sole purpose of that consult. Rather, recommending specific procedures or other pain management treatments would be within the domain of the pain management consultation and would be supported given the complexity of this case. This request is medically necessary.

2. L4/L5 bilateral facet injections and rhizotomy is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM guidelines and Official Disability Guidelines.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers’ Compensation, the Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Low Back, Facet Injections.

The Physician Reviewer’s decision rationale:

The ACOEM Guidelines do not directly address facet injections. The Official Disability Guidelines/Treatment of Workers' Compensation/Low Back states regarding therapeutic facet injections, “Under study...Current evidence is conflicting as to this procedure.” In addition, it is not apparent that this patient’s presentation with radicular symptoms is consistent with facet mediated pain, as the guidelines note, “There should be no evidence of radicular pain, spinal stenosis, or previous fusion.” The same reference discusses rhizotomy after diagnostic facet injections have been performed but not simultaneously with intraarticular facet injections. For these multiple reasons, this request should be noncertified. This request is not medically necessary.

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[REDACTED]

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