

Case Number:	CM13-0001639		
Date Assigned:	01/10/2014	Date of Injury:	03/31/2000
Decision Date:	03/24/2014	UR Denial Date:	07/09/2013
Priority:	Standard	Application Received:	07/16/2013

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 Internal Medicine and Emergency Medicine, and is licensed to practice in Florida. 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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

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

This patient is a 50 year-old with a date of injury of 03/31/00. A progress report associated with the request for services, dated 06/20/13, identified subjective complaints of low back pain into the leg. She noted that pain had reoccurred since the radiofrequency ablation on the left side. Objective findings included tenderness of the facet joints and pain with range-of-motion. Motor and sensory function was intact. Diagnoses included bilateral lumbar facet joint pain. Treatment has included a left radiofrequency ablation at L3-4, L4-5, and L5-S1 and right sided ablation in 03/13. A Utilization Review determination was rendered on 07/09/13 recommending non-certification of Left Side Lumbar Radiofrequency L4-5 and L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Side Lumbar Radiofrequency L4-5 and L5-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Acute & Chronic), Criteria for use of facet joint radiofrequency neurotomy

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, Facet Joint Radiofrequency Neurotomy.

Decision rationale: The Physician Reviewer's decision rationale: Medical Treatment Utilization Schedule (MTUS) Guidelines note that radiofrequency neurotomy also called facet rhizotomy of facet joint nerves of the cervical spine provides good temporary relief of pain. Similar quality literature does not exist for the lumbar region and those neurotomies produce mixed results. They further note that facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The Official Disability Guidelines (ODG) state that studies have not demonstrated improved function. They list the following criteria for use: - Only after a positive diagnostic medial branch block. - Repeat neurotomies should not occur at an interval of less than 6 months from the first procedure. - A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at > 50% relief. - Repeat neurotomies depend on evidence such as improvement in pain, decreased medications, and documented improvement in function. - If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks. - There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. In this case, there is no evidence of a prior diagnostic medial branch block, pain relief of > 50% for at least 12 weeks, or a formal plan of evidenced-based conservative care. Six months had not occurred since the original ablation. Likewise, there is little evidence recommending lumbar facet radiofrequency ablations. Therefore, there is no documented medical necessity for the lumbar radiofrequency ablations.