

Case Number:	CM13-0010972		
Date Assigned:	03/24/2014	Date of Injury:	04/05/2012
Decision Date:	06/30/2014	UR Denial Date:	08/08/2013
Priority:	Standard	Application Received:	08/14/2013

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. The expert reviewer is Board Certified in Occupational Medicine 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 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/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 is a 36 year old male who reported neck and back pain after a motor vehicle accident on 04/05/2012. Radiographs and MRIs of the cervical and lumbar spine showed some degenerative changes without definite nerve root compression. He has been diagnosed with cervical spine strain/sprain, lumbar spine strain/sprain, and bilateral lower extremity radiculopathy. The AME diagnosed sciatica and recommended the option for lumbar epidural steroid injection, but did not mention facet procedures. The treatment has included medications, a back brace, physical therapy, chiropractic, and injections. On 2/19/13, the treating physician performed bilateral L2 to L4 medial branch blocks, with sedation. Pain relief was not substantial. On 7/8/2013 the injured worker underwent bilateral L4, L5 and S1 medial branch blocks with Marcaine. "Sedation" was given but not identified in the procedure report. There was no report of the immediate post-procedure results. Per the PR2 of 7/19/13, medial branch blocks helped "by 80%" for two days. There was ongoing low back pain with signs of radiculopathy. Lumbar radiofrequency ablation was recommended, followed by use of a hot-cold unit. On 8/8/13 Utilization Review non-certified the radiofrequency ablation, noting the lack of sufficient indications per the AME and guidelines. The hot-cold unit had been prescribed for use after the procedure so this unit was not certified in light of the non-certification for the radiofrequency ablation. The California MTUS and the Official Disability Guidelines were cited in support of the decisions.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 MEDIAL BRANCH FACET RHIZOTOMY AND NEUROLYSIS: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Facet joint radiofrequency neurotomy, Facet joint pain, signs & symptoms, Facet joint diagnostic blocks (injections)

Decision rationale: Per page 300 of the ACOEM Guidelines, lumbar facet neurotomies and differential medial branch blocks may be useful. The Official Disability Guidelines recommends against facet joint injections, and provides equivocal support for medial branch blocks followed by radiofrequency ablation. The California MTUS, Chronic Pain section, does not provide direction for medial branch blocks. The proper procedure for performing facet blocks/medial branch blocks is described in a number of publications, including the Official Disability Guidelines. The procedures performed in February and July were not performed according to the guidelines. Sedation was used, which is grounds to negate the procedure according to guidelines. There was no detailed account of immediate post-procedure pain relief and function. The Official Disability Guidelines recommends "The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control." There is no record of this kind of log. The duration of pain relief is not consistent with the anesthetic used. The volume of injectate was greater than the amount recommended in the Official Disability Guidelines. There is no record that the injured worker did not take pain medications prior to the procedure. The Official Disability Guidelines recommends against facet radiofrequency ablation in patients with radiculopathy; this patient has been diagnosed with radiculopathy. The radiofrequency ablation is not medically necessary based on lack of the specific indications per the cited guidelines.

HOT/COLD THERAPY UNIT & SUPPLIES (RENTAL OR PURCHASE): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Cold/heat packs; Continuous-flow cryotherapy, Heat therapy

Decision rationale: According to the Official Disability Guidelines, heat and cold packs are recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. Continuous cryotherapy device is recommended as an option after knee and shoulder surgery, but not for nonsurgical treatment. There is inadequate clinical evidence to substantiate that hot-cold unit is more efficacious than standard ice/cold and hot packs. The references state that mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. Simple at home applications of heat and cold are thought to suffice for delivery of heat

or cold therapy. The device was prescribed in this case for use after the radiofrequency ablation procedure. The radiofrequency ablation procedure is not medically necessary, and therefore any associated services like this unit are also not medically necessary.