

Case Number:	CM13-0022448		
Date Assigned:	12/27/2013	Date of Injury:	10/18/2010
Decision Date:	02/21/2014	UR Denial Date:	09/05/2013
Priority:	Standard	Application Received:	09/10/2013

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 Anesthesiologist, Pain 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:

The patient is a 51-year-old female who reported an injury on 10/18/2010. The mechanism of injury information was not provided in the medical record. The patient was diagnosed with cervical spine sprain and strain with bilateral upper extremity radiculopathy with mild disc bulging 3 mm at C4-5, two mm to 3 mm at C5-6, and 2 mm at C2-3 with 3.4 mm retrolisthesis at C5 on C6 stenosis, as per the MRI scan dated 07/22/2011. The patient was diagnosed with lumbar spine sprain and strain with mild disc bulging 5 mm disc bulge at L4-S1, four mm at L4-5, and 3 mm with facet hypertrophy/IVF stenosis at L4-S1, as per the MRI scan on 03/03/2012. The patient was also diagnosed with right sacroiliac joint sprain and strain, the right greater than the left, with pain due to right shoulder strain. The most recent clinical note dated 09/10/2013 reports that the patient had undergone her first injection and stated that her pain was decreased. She no longer experienced pain at 10/10; she stated her pain was now 6/10. The patient stated she is still unable to sleep on her side and she is taking Norco 1 every other day because she did not have enough medication to take them daily in order to reduce her pain. Objective findings were positive right sacroiliac joint compression test, positive right Yeoman's sign, and straight leg raise was noted to be negative. The patient stated she was using ibuprofen 600 mg 2 tablets between each Norco. It is also noted in the clinical note dated 09/10/2013 that the patient was seeing a chiropractor, [REDACTED]. The patient returned with continued complaints of daily moderate to severe low back pain that was frequent and increased with bending, sitting, standing, or lifting. Examination of the lumbar spine revealed that her active range of motion overall was moderately decreased with +1 pain in the lumbar spine and sacroiliac joint region. Pain was also noted over the lumbar spine paraspinal muscles with noted myospasms. The right sacroiliac joint

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Sacroiliac joint rhizotomy: 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), Hip Chapter.

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

Decision rationale: The Physician Reviewer's decision rationale: California MTUS/ACOEM does not address sacroiliac joint rhizotomies. Per Official Disability Guidelines, sacroiliac joint radiofrequency neurotomy, or rhizotomy, is not recommended. The innervations of the sacroiliac joint remains unclear, and there is also controversy over the correct technique for radiofrequency denervation. A recent review of this intervention by American Society of Interventional Pain Physicians, found that evidence was limited for this particular procedure. As such, the medical necessity for the requested service cannot be proven, therefore, the request for Right Sacroiliac joint rhizotomy is non-certified.

Bilateral L4-S1 medial branch facet joint rhizotomy and neurolysis, #2: 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 Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Facet joint medial branch blocks (therapeutic injections).

Decision rationale: The Physician Reviewer's decision rationale: California MTUS ACOEM states 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. Per Official Disability Guidelines, facet joint radiofrequency neurotomies are under study and should only be performed after a diagnosis of facet joint pain using a medial branch block has been accomplished. There is no clinical documentation provided in the medical record suggesting the patient has in fact received a previous diagnostic medial branch block. Without the documented diagnostic medial branch block, the medical necessity for the requested service cannot be proven. As such, the request for Bilateral L4-S1 medial branch facet joint rhizotomy and neurolysis, #2 is non-certified.

Hot and cold therapy unit (duration unspecified): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross/Blue Shield Medical Policy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

Decision rationale: The Physician Reviewer's decision rationale: Per California MTUS/ACOEM, it is optional for the patient to apply local heat or cold packs to the lower back. The application of the heat or cold packs is not in reference to continuous hot to cold therapy units. Official Disability Guidelines state that hot and cold packs are recommended as an option for acute pain. Home local applications of cold packs are recommended in the first few days of acute complaint; however, thereafter, continuous low level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low back pain is more limited than heat therapy. There is minimal evidence supporting the use of cold therapy. As such, the request for the hot and cold therapy unit is not medically necessary at this time. The request also does not have any specific duration that the requested service would be in use for. Therefore, the request for the hot and cold therapy unit cannot be certified at this time.