

Case Number:	CM13-0039910		
Date Assigned:	12/20/2013	Date of Injury:	04/13/2005
Decision Date:	02/24/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/28/2013

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 Family Practice 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. 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 58-year-old male who reported an injury on 04/13/2005. The mechanism of injury was stated to be the patient is a California highway patrolman and was lifting weights. The patient was noted to have left leg weakness. The patient was noted to have manual muscle testing in the office on the date of 10/23/2013 which revealed the patient had a 4/5 on the right lower extremity and a 3/5 on the left lower extremity. The patient was noted to have escalating low back pain and 70% pain relief after a medial branch block along with 50% less opiates during post procedure times. The patient was noted to have ongoing pain in the bilateral feet with feeling of sharp needles and burning in the bilateral feet times 3 weeks. The patient was noted to have tenderness at the base of the heel with a visible bluish-reddish color change, plantar aspect of the bilateral feet with allodynia and coldness to touch. The request was made for a right, then left, L4-5 radiofrequency ablation, bilateral lower extremity EMG/NCS, and Voltaren gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV BLE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM and ODG.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Low Back Chapter, NCS.

Decision rationale: ACOEM states that Electromyography (EMG), including H reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The clinical documentation submitted for review failed to indicate documentation of the patient's conservative care. Official Disability Guidelines do not recommend NCS as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The clinical documentation submitted for review indicated the patient had signs and symptoms on the left side. However, there was a lack of documentation of dermatomal and myotomal findings to support the requested services. There was a lack of documentation indicating the necessity for both studies. Given the above, the request for an EMG/NCV of the bilateral lower extremities is not medically necessary.

Injection lumbar spine right then left L4-L5 Radiofrequency: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM and ODG.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Low Back Chapter, Facet joint radiofrequency neurotomy.

Decision rationale: ACOEM guidelines indicate that radiofrequency neurotomy for the treatment of select patients with low back pain is recommended as there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. 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. The Official Disability Guidelines indicate radiofrequency neurotomies are under study and they recommend repeat neurotomies for patients who have documentation of a duration of relief from the first procedure for at least 12 weeks at \geq 50% relief. Additionally, the approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in Visual Analog Scale (VAS) score, decreased medications, and documented improvement in function. Also, there should be a formal plan of additional evidence-based conservative care in addition to facet joint therapy. The clinical documentation submitted for review while indicating the patient had a 70% relief after a medial bundle branch block and 50% less opiates, failed to include the duration the patient had the relief. Additionally, it failed to indicate the laterality for the prior injection. There was a lack of documentation of decreased medications along with documented improvement in function and a formal plan of additional evidence based conservative care in addition to the facet joint therapy. There was a lack of documentation indicating the interval between the left and right injections. Given the above and the lack of clarification, the request for injection lumbar spine right then left L4-5 radiofrequency is not medically necessary.

Voltaren 1% Gel: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 111.

Decision rationale: CA MTUS states Voltaren® Gel 1% (diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The clinical documentation submitted for review failed to provide the patient had osteoarthritis pain in the joints and failed to indicate what joint the medication would be used on as it has not been evaluated for treatment in the spine, hip, or shoulder. Per the submitted documentation, there was a lack of documentation of quantity being requested. Given the above, the request for Voltaren 1% gel, is not medically necessary