

Case Number:	CM13-0050680		
Date Assigned:	12/27/2013	Date of Injury:	10/02/2008
Decision Date:	03/11/2014	UR Denial Date:	10/31/2013
Priority:	Standard	Application Received:	11/14/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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 40-year-old male who reported an injury on 10/02/2008 due to a twisting motion that reportedly caused injury to his right knee and low back. The patient's chronic pain was managed with physical therapy and medications. The patient underwent an MRI in 06/2013 that revealed bilateral multilevel facet arthropathy. The patient underwent bilateral medial branch blocks at the L4, L5 and S1 facet joint levels. The patient's most recent clinical evaluation revealed that the patient had 75% improvement in back pain with improved range of motion for approximately 30 minutes after the injection that lasted greater than 2 hours. Physical findings included tenderness upon palpation of the lumbar paraspinal musculature overlying the bilateral L3 through S1 facet joints. The patient's diagnoses include bilateral lumbar facet joint pain from the L3 through the S1 and lumbar facet joint arthropathy. The patient's treatment plan included radiofrequency ablation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Decision for radiofrequency nerve ablation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 Chapter, Facet joint radiofrequency neurotomy

Decision rationale: The requested radiofrequency nerve ablation is not medically necessary or appropriate. Official Disability Guidelines recommend that radiofrequency ablation be considered for patients who have a positive response to a diagnostic facet joint injection. Official Disability Guidelines define a positive response as greater than 70% pain relief for at least 2 hours with documentation of functional benefit. The clinical documentation submitted for review does indicate that the patient had 75% pain relief with increased range of motion for approximately 2 hours after the initial medial branch block. The patient's most recent physical evaluation did reveal that the patient had facet mediated pain. This was supported by an MRI study that showed evidence of facet arthropathy. Additionally, the clinical documentation submitted for review did not provide any evidence of radiculopathy. However, Official Disability Guidelines also state there should be evidence of a formal plan for additional evidence based conservative care in addition to facet joint therapy. The clinical documentation submitted for review does not indicate that the patient will be participating in any active therapy in conjunction with the patient's facet joint therapy. Therefore, the radiofrequency ablation is not medically necessary or appropriate.

Decision for fluoroscopically bilateral L4-L6 and bilateral L6-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 Chapter, Facet joint radiofrequency neurotomy

Decision rationale: The requested fluoroscopically bilateral L4-L6 and bilateral L6-S1 is not medically necessary or appropriate. The clinical documentation does not support radiofrequency ablation at this time. Although Official Disability Guidelines do recommend that this intervention be performed with fluoroscopic guidance, the actual intervention is not supported at this time. Therefore, the need for fluoroscopically bilateral L4-L6 and bilateral L6-S1 is not medically necessary or appropriate.