

Case Number:	CM14-0105107		
Date Assigned:	07/30/2014	Date of Injury:	11/04/2012
Decision Date:	09/29/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/07/2014

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 43-year-old female with an 11/4/12 date of injury; the mechanism of the injury was not described. The patient was seen on 5/23/14 with complaints of increase in spine and left sided leg pain with occasional numbness and tingling. The patient rated her pain 6-7/10 and stated that bending and getting up from the chair aggravated the pain. The note stated that the patient had radiofrequency ablation in last October and that it started to wear off and was very helpful. Exam findings revealed slightly antalgic gait, tenderness to palpation in the paraspinal lumbar muscles bilaterally, tender buttocks and the patient was not able to squat due to pain. The range of motion in the lumbar spine was within normal limits and the sensation was intact in the lower extremities bilaterally. The diagnosis is lumbar disc displacement, lumbar spondylosis, depressive psychosis and chronic pain syndrome. Treatment to date: work restrictions, medications, physical therapy, cognitive behavioral therapy, lumbar facet joint rhizotomy and biofeedback training. An adverse determination was received on 6/20/14. The determination letter was not available for the review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient referral for radiofrequency ablation: 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): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

Decision rationale: CA MTUS states that facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. In addition, ODG criteria for RFA include at least one set of diagnostic medial branch blocks with a response of 70%, no more than two joint levels will be performed at one time, and evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. ODG criteria for RFA include evidence of adequate diagnostic blocks, documented improvement in VAS score, documented improvement in function, evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy, at least 12 weeks at 50% relief with prior neurotomy, and repeat neurotomy to be performed at an interval of at least 6 months from the first procedure. The progress note dated 5/23/14 indicated that the patient underwent radiofrequency ablation in October 2013 with benefit. However, there is a lack of documentation with regards to the improvement in the patient's function and improvement in VAS score with the previous radiofrequency ablation. In addition, it is not clear how many radiofrequency sessions the patient underwent. Therefore, the request for Outpatient referral for Radiofrequency Ablation is not medically necessary.

Purchase of Pro-Stim 5.0 with supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS UNIT Page(s): 114-116.

Decision rationale: Pro-Stim is a combination of TENS unit and electrical muscle stimulation unit. CA MTUS Chronic Pain Medical Treatment Guidelines state that TENS units are not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. Criteria for the use of TENS unit include Chronic intractable pain - pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, and a treatment plan including the specific short- and long-term goals of treatment with the TENS unit. It is not clear if the patient have tried Pro-Stim before. In addition, the progress notes did not indicate that the patient suffered from chronic untraceable pain and there is no rationale with regards to where the Pro-Stim would be applied. In addition, there are no clearly specified goals of treatment with this medical device. Therefore, the request for Purchase of Pro-Stim 5.0 with supplies is not medically necessary.