

Case Number:	CM14-0011537		
Date Assigned:	02/28/2014	Date of Injury:	04/18/2005
Decision Date:	06/30/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	01/29/2014

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 Physical Medicine and Rehabilitation, 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:

The injured worker is a 42-year-old male who reported an injury on 04/18/2005 due to falling off his work truck. The clinical note dated 10/24/2013 noted the injured worker presented with a complaint of low back pain. Prior treatments include physical therapy, TENS unit, massage, heat and ice. Upon exam, there is low back and neck pain, decreased range of motion, fibromyalgia, middle back pain, joint pain, muscle tenderness, neck mass, joint swelling, neck stiffness, muscle cramps, and muscle weakness. The diagnoses were syndrome of chronic pain, lumbosacral spondylosis without myelopathy, lumbar radiculopathy, lumbar degenerative disc disease, and low back pain. The provider recommended a lumbar radiofrequency ablation at L3, L4, and L5, Valium, and oxycodone. The Request for Authorization Form was dated 01/15/2014; however, the provider's rationale was not included in the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR RADIO FREQUENCY ABLATION OF L3, L4 AND L5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, OMPG, SECOND EDITION (2004), CHAPTER 12, LOW BACK COMPLAINTS, 300

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Facet Joint Radiofrequency Neurotomy.

Decision rationale: The ACOEM/California MTUS Guidelines state that 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 neurotomy should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The Official Disability Guidelines further state that facet joint radiofrequency/neurotomies are recommended as a treatment that requires a diagnosis of facet joint pain using a medial branch. There should be evidence of a verbal plan and additional evidence based conservative care in addition to facet therapy. The request for lumbar radiofrequency ablation of L3, L4, and L5 exceeds the recommendations of the guidelines. The guidelines recommend that no more than two joint levels are to be performed at one time. The requesting physician did not include adequate documentation of significant physical examination findings congruent with facetogenic pain. There was a lack of documentation detailing whether the injured worker had a diagnostic blocks for facet joints. As such, the request is not medically necessary.

VALIUM 5 MG ONE TAB, ONE HOUR PRE PROCEDURE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 24,66

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

ROXICODONE 15 MG ONE TAB ONE HOUR PREPROCEDURE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 76-80

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.