

Case Number:	CM14-0111711		
Date Assigned:	08/01/2014	Date of Injury:	03/18/2010
Decision Date:	09/17/2014	UR Denial Date:	07/10/2014
Priority:	Standard	Application Received:	07/17/2014

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 Orthopedic Spine Surgery 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 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 56-year-old male who reported injury on 03/18/2010. The mechanism of injury was unloading chairs. The diagnostic studies and prior therapies were not provided. The prior treatments included a lumbar radiofrequency ablation at L4, L5 and S1 bilaterally. The documentation of 05/14/2014 revealed the injured worker had a good outcome with his radiofrequency thermocoagulation for 1 year with good overall pain control. The injured worker indicated pain was slowly coming back. The medications were noted to include ibuprofen 800 mg. The physical examination of the lumbar spine revealed the injured worker had range of motion that was restricted by pain. The injured worker had tenderness over L3, L4 and L5. The lumbar facet loading was positive bilaterally. The faber test was positive. The diagnoses included lumbar back pain syndrome, lumbar thoracic radiculopathy, lumbar stenosis, lumbar disc herniation without myelopathy, post laminectomy syndrome cervical and cervical spondylosis and facet arthropathy. The treatment plan included a lumbar radiofrequency ablation at L3, L4, L5 and S1. There was a Request for Authorization form submitted for the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar radiofrequency ablation at L3, L4, L5 and S1: 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, updated 7/3/14, Facet joint radiofrequency neurotomy.

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 diagnostic blocks (injections).

Decision rationale: The American College of Occupational and Environmental Medicine Guidelines indicate that a facet neurotomy (Rhizotomy) should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As the guidelines does not address specific criteria for medial branch diagnostic blocks, secondary guidelines were sought. The Official Disability Guidelines indicate the criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings although pain may radiate below the knee, and a normal straight leg raise exam. There should be documentation of failure of conservative treatment including home exercise, physical therapy, and non-steroidal anti-inflammatory drugs (NSAIDS) prior to the procedure for at least 4 to 6 weeks and no more than 2 facet joint levels should be injected in 1 session. The clinical documentation submitted for review indicated the injured worker had previously undergone a radiofrequency ablation at L4, L5 and S1. There was a lack of documentation indicating the injured worker had an involvement of the L3 level. As such, this would be considered a diagnostic block. There was documentation of tenderness to palpation at the paravertebral area. There was a lack of documentation of a normal sensory examination, and the absence of radicular findings. It was documented the straight leg raise was negative and the lower extremity reflexes were equal and symmetric. However, there was a lack of documentation of failure of conservative treatment including home exercises, physical therapy and NSAIDs prior to the procedure for at least 4 to 6 weeks. There was a lack of documented rationale for a necessity to include 4 levels for injection. Given the above, the request for a lumbar radiofrequency ablation at L3, L4, L5 and S1 is not medically necessary.