

Case Number:	CM14-0111900		
Date Assigned:	08/01/2014	Date of Injury:	09/16/1995
Decision Date:	09/09/2014	UR Denial Date:	06/27/2014
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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 44-year-old male with a 9/16/95 date of injury. At the time (6/12/14) of request for authorization for Facet joint radiofrequency Neurotomy injection - Bilateral - L3, L4, L5; Injection to left greater trochanter performed on 6/12/14, and Injection to right greater trochanter performed on 6/12/14, there is documentation of subjective and objective findings. The subjective findings include ongoing moderate to severe pain in the lower back, mostly axial in nature; and right knee and right shoulder pain. The objective findings include tenderness to palpation over the lumbar spine with increased muscle rigidity bilaterally, palpable trigger points throughout the lumbar paraspinal musculature, decreased lumbar range of motion, and positive facet loading in the low back region; point tenderness over the bilateral hips; tenderness to palpation over the right knee anterior joint line with swelling and crepitus on range of motion; left below-knee stump with redness along the medial aspect of the knee and tenderness along the medial and lateral joint lines of the left knee. The current diagnoses are lumbar spine sprain/strain, lumbar facet arthropathy, left lower extremity radiculopathy, left below-knee amputation, and right knee internal derangement. The treatment to date includes lumbar radiofrequency ablation on 9/23/13 with greater than 50% pain relief for five to six months, improvement in VAS score, and improved mobility and activity tolerance; adequate lumbar medial branch blocks, medications, and physical therapy. In addition, medical report identifies a request for repeat facet radiofrequency neurotomy at bilateral L3, L4 and L5 in conjunction with exercise; and Kenalog injection into right and left greater trochanter. Furthermore, medical reports identify certification of a facet rhizotomy at bilateral L3, L4 and L4 on 6/24/14. Regarding Facet joint radiofrequency Neurotomy injection - Bilateral - L3, L4, L5, there is no documentation that no more than two joint levels will be performed at one time. Regarding Injection to left greater trochanter performed on 6/12/14 and Injection to right greater

trochanter performed on 6/12/14, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which trochanteric injections are indicated (greater trochanteric pain syndrome/trochanteric bursitis).

IMR ISSUES, DECISIONS AND RATIONALES

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

Facet joint radiofrequency Neurotomy injection - Bilateral L3, L4, L5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Low Back.

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, Facet joint radiofrequency neurotomy.

Decision rationale: MTUS reference to ACOEM guidelines state that lumbar facet neurotomies reportedly produce mixed results and that facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. Official Disability Guidelines identifies documentation of evidence of adequate diagnostic blocks, documented improvement in VAS score, documented improvement in function, no more than two joint levels will be performed at one time, 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, as criteria necessary to support the medical necessity of repeat facet joint radiofrequency neurotomy. Within the medical information available for review, there is documentation of diagnoses of lumbar spine sprain/strain, lumbar facet arthropathy, left lower extremity radiculopathy, left below-knee amputation, and right knee internal derangement. In addition, there is documentation of a previous radiofrequency neurotomy injection at bilateral L3, L4, L5 performed on 9/23/13. Furthermore, there is documentation of evidence of adequate diagnostic blocks, improvement in VAS score, improvement in function, evidence of a formal plan of additional evidence-based conservative care (exercise and medications) 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. However, given documentation of a request for Facet joint radiofrequency Neurotomy injection - Bilateral - L3, L4, L5, there is no (clear) documentation that no more than two joint levels will be performed at one time. In addition, given documentation of a 6/24/14 certification for facet rhizotomy at bilateral L3, L4 and L4, there is no documentation of a rationale identifying the medical necessity for the current requested Facet joint radiofrequency Neurotomy injection- Bilateral - L3, L4, L5. Therefore, based on guidelines and a review of the evidence, the request for Facet joint radiofrequency Neurotomy injection - Bilateral - L3, L4, L5 is not medically necessary.

Injection to left greater trochanter performed on 6/12/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Hip & Pelvis.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Trochanteric bursitis injections.

Decision rationale: MTUS does not address this issue. Official Disability Guidelines identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which trochanteric injections are indicated (such as: greater trochanteric pain syndrome/trochanteric bursitis), as criteria necessary to support the medical necessity of trochanteric injections. Within the medical information available for review, there is documentation of diagnoses of lumbar spine sprain/strain, lumbar facet arthropathy, left lower extremity radiculopathy, left below-knee amputation, and right knee internal derangement. In addition, there is documentation of a request for Kenalog injection into left greater trochanter. However, despite documentation of subjective (ongoing moderate to severe pain in the lower back, mostly axial in nature; and right knee and right shoulder pain) and objective (point tenderness over the bilateral hips) findings, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which trochanteric injections are indicated (greater trochanteric pain syndrome/trochanteric bursitis). Therefore, based on guidelines and a review of the evidence, the request for Injection to left greater trochanter performed on 6/12/14 is not medically necessary.

Injection to right greater trochanter performed on 6/12/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Hip & Pelvis.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Trochanteric bursitis injections.

Decision rationale: MTUS does not address this issue. Official Disability Guidelines identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which trochanteric injections are indicated (such as: greater trochanteric pain syndrome/trochanteric bursitis), as criteria necessary to support the medical necessity of trochanteric injections. Within the medical information available for review, there is documentation of diagnoses of lumbar spine sprain/strain, lumbar facet arthropathy, left lower extremity radiculopathy, left below-knee amputation, and right knee internal derangement. In addition, there is documentation of a request for Kenalog injection into right greater trochanter. However, despite documentation of subjective (ongoing moderate to severe pain in the lower back, mostly axial in nature; and right knee and right shoulder pain) and objective (point tenderness over the bilateral hips) findings, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which trochanteric injections are indicated (greater trochanteric pain syndrome/trochanteric bursitis). Therefore, based on guidelines and a review of the evidence, the request for Injection to right greater trochanter performed on 6/12/14 is not medically necessary.