MAXIMUS Federal Services

Case Number:	CM14-0113761		
Date Assigned:	08/01/2014	Date of Injury:	03/11/2004
Decision Date:	09/17/2014	UR Denial Date:	07/11/2014
Priority:	Standard	Application Received:	07/21/2014

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 Nevada. 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 records presented for review, indicate that this 46-year-old female was reportedly injured at work on 3/11/2004. The mechanism of injury is not listed. The most recent progress note is the utilization review dated 7/11/2014. There were no reports from the treating physician submitted for review. It indicated that there were ongoing complaints of neck pain that radiated to both shoulders, bilateral wrists pain and low back pain. The physical examination, documented in this utilization review, stated decreased range of motion in the cervical spine, positive tenderness of both shoulders and diminished light touch in the median and ulnar distributions. Positive impingement signs. Left side was affected more than the right side. Phalen's test was positive in the right hand/wrist. Thoracic spine revealed decreased range of motion. Lumbar spine revealed decreased range of motion. Bilateral knees revealed effusion and medial joint line tenderness. Steinman's test was positive on the right and left. No recent diagnostic studies are available for review. Previous treatment included arthroscopy, injections, cervical fusion, carpal tunnel release, previous medial branch blocks, and postoperative physical therapy. A request was made for lumbar facet rhizotomy bilateral at L4-L5 and L5-S1 following medial branch blocks, interferential (IF) unit and was not certified in the pre-authorization process on 7/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar facet rhizotomy bilateral at L4-5 & L5-S1 following medial branch blocks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official disabilities guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG -TWC/ODG Integrated Treatment/Disability Duration Guidelines; Low Back - Lumbar & Thoracic (Acute & Chronic) - Facet Joint Radiofrequency Neurotomy (updated 07/03/14).

Decision rationale: MTUS/ACOEM practice guidelines makes no recommendation for or against the use of facet rhizotomy for patients with chronic back pain confirmed with diagnostic blocks, but without radiculopathy and who have failed conservative treatment. ODG require specific criteria be met for the use of a facet joint radiofrequency to include diagnosis of facet joint pain using a medial branch block injection and evidence of a formal plan of additional evidence-based conservative care. In addition, no more than 2 joints levels be performed at one time and the procedure should not be repeated within 6 months. Review of the available medical records states a 70% relief after prior medial branch block date unknown for several weeks. After review of the criteria and medical records, it is noted that the patient had improvement from prior medial branch blocks; however, the date of injection is unknown as well as how long the benefit was present. Lacking pertinent information, this request is deemed not medically necessary.

IF unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 118-120.

Decision rationale: MTUS guidelines do not support interferential therapy as an isolated intervention. The guidelines will support a one-month trial in conjunction with physical therapy, exercise program and a return to work plan if chronic pain is ineffectively controlled with pain medications or side effects to those medications. Review of the available medical records failed to document any of the criteria required for an interferential (IF) unit one-month trial. As such, this request is not medically necessary.