

Case Number:	CM14-0130430		
Date Assigned:	08/18/2014	Date of Injury:	02/03/2013
Decision Date:	09/18/2014	UR Denial Date:	08/11/2014
Priority:	Standard	Application Received:	08/15/2014

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 & 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 of an unknown age, female, and reported an injury on 02/03/2013 due to an unknown mechanism. Diagnoses were not reported. Past treatment was physical therapy and 2 epidural steroid injections. An MRI revealed at the L4-5 there was modic endplate changes and advanced degenerative disc disease with a posterior annular tear and central disc bulge and contained herniation. There was a left-sided disc herniation at the L3-4 with degenerative changes, and mild degenerative changes above L2-3. There were advanced degenerative changes with the central disc bulge at the L5-S1. Surgical history was not reported. Subjective complaints were not reported. The physical examination revealed the injured worker could touch her fingertips to her knees. Extension was to 20 degrees. Straight leg raise was negative bilaterally. Medications were not reported. The treatment plan was for an epidural steroid injection at the L4-5. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Epidural Steroid (ESI) x 3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: The request for Lumbar Epidural Steroid (Epidural Steroid Injection, page 51) x 3 is non-certified. California MTUS guidelines recommend for an Epidural Steroid injection that Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing and the pain must be initially unresponsive to conservative treatment including exercise, physical therapy, NSAIDS and Muscle Relaxants. No more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level should be injected at one session. There were no corroborating physical findings or imaging findings to support the medical necessity of an Epidural Steroid Injection. The outcome of the 2 previous injections with pain relief and functional improvement were not reported. Medications were not reported. Previous conservative care was not reported. Therefore, the request is non-certified.

Facet Radio Frequency Ablation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

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, Facet Joint Radiofrequency Neurotomy.

Decision rationale: The request for Facet Radio Frequency Ablation is non-certified. ACOEM guidelines indicate that radiofrequency neurotomy for the treatment of select patients with low back pain is recommended as 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 neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As there was a lack of criteria for the use of neurotomies, secondary guidelines were sought. The Official Disability Guidelines indicate radiofrequency neurotomies are under study. However the criteria for the use of diagnostic blocks if requested indicates that the patient should have facet-mediated pain which includes tenderness to palpation in the paravertebral area over the facet region, a normal sensory examination, absence of radicular findings and a normal straight leg raise exam. Additionally, one set of diagnostic medial branch blocks is required with a response of 70%, and it is limited to no more than 2 levels bilaterally. The injured worker's functional improvement from the previous epidural steroid injections were not reported. There was no radicular findings on examination and corroborated with imaging. Therefore, the request is non-certified.