

Case Number:	CM14-0032857		
Date Assigned:	06/23/2014	Date of Injury:	12/27/2005
Decision Date:	08/05/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	03/15/2014

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 Spinal Surgery and is licensed to practice in New York. 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:

A 42 year-old male with chronic back pain. DOI 12/27/05. An MRI on 3/08/05 shows L4-5 broad-based disc protrusion and L5-S1 small disc protrusion. An EMG from 2013 shows left L5 radiculopathy. Patient has worsening of left radiculopathy. The patient has had NSAIDs and cortisone injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L5 Dorsal Root Ganglion Radio-Frequency Neurotomy QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Criteria for use of facet joint radiofrequency neurotomy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter, Criteria for use of therapeutic intra-articular and medical branch blocks.

Decision rationale: This patient has chronic axial back pain. He has MRI-documented 2 -level degenerative back changes at both L4-5 and L3-4. He had transforaminal injection with 20% pain relief. As per ODG Guidelines, he did not have medial branch block treatment documenting initial 70% relief of pain symptoms and documented at least 50% for a 6-week duration relief.

He does not meet established criteria for facet ablation therapeutic injection treatments. Also, he has documented radiculopathy which is a contraindication to ablation treatment. They are not medically necessary and not more likely than continued conservative measures to provide lasting back pain relief.