

Case Number:	CM14-0049487		
Date Assigned:	07/07/2014	Date of Injury:	05/11/2012
Decision Date:	08/06/2014	UR Denial Date:	03/31/2014
Priority:	Standard	Application Received:	04/17/2014

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 Physical Medicine and Rehabilitation has a subspecialty in Interventional Spine 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 patient is a 37 year old with an injury date on 5/11/12. Patient complains of low back pain that feels like a lot of pressure per 3/19/14 report. Patient's pain is greater on left side, and there is intermittent radiation of pain into his left lower extremity and left foot with numbness/tingling per 2/19/14 report. Pain is increased with walking more than 1 block, driving more than 20 minutes, and after sexual intercourse per 2/19/14 report. Patient complains that buprenorphine is not effective in pain relief in 3/19/14 report. Based on the 3/19/14 progress report provided by [REDACTED] the diagnosis is spondylosis lumbosacral. Exam of L-spine on 3/19/14 showed range of motion: extension is 10 degrees, flexion is 50 degrees, tenderness to palpation over bilateral lower lumbar facet joints, pain with loading of these facet joints. Straight leg raise is negative; spasm/guarding is noted in L-spine with a normal neurologic exam. [REDACTED] is requesting bilaterally permanent lumbar facet injection (AKA radio ablation) at L3-4 and L4-5 with fluoroscopic guidance, IV sedation. The utilization review determination being challenged is dated 3/31/14 and rejects request due to patient's insufficient response to medial branch block. [REDACTED] is the requesting provider, and he provided treatment reports from 1/30/14 to 3/31/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilaterally permanent lumbar facet injection (AKA Radio Frequency Ablation) at L3-4 and L4-5 with fluroscopic guidance, IV sedation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation ODG Guidelines, Low Back Chapter for Facet Joint Radio Frequency Neurotomy and ODG-TWC Guidelines, Hip Chapter, for Sacroiliac Joint Radio Frequency Neurotomy.

Decision rationale: This patient presents with lower back pain. The treater has asked for bilaterally permanent lumbar facet injection (AKA radio ablation) at L3-4 and L4-5 with fluoroscopic guidance, IV sedation on 3/19/14. Review of the 3/19/14 report shows patient had a diagnostic facet injection on 10/15/13 which provided him pain relief for 4-5 days and pain decreased from 8-9/10 down to 3-4/10. Another medial branch block on 3/4/14 only gave temporary benefit per 3/14/14 report. No prior radiofrequency rhizotomy was shown in patient's medical history. For radio frequency neurotomy of L-spine, ACOEM states that it gives mixed results, and ODG recommends on a case-by-case basis, after a positive response to a facet diagnostic block. In this case, the patient appears to have had mixed results following two diagnostic DMB blocks. ODG Guidelines require documentation of 70% reduction of pain lasting the duration of medication used. In this case, the patient appears to have had a placebo response with 50-60% (8-9/10 to 3-4/10) reduction lasting much longer than the anticipated duration of local anesthetic. Second diagnostic did not result in greater 70% reduction pain either. Radio Frequency Ablation would not be indicated in this situation. The request for Bilaterally Permanent Lumbar Facet Injection (AKA Radio Frequency Ablation) At L3-4 And L4-5 with fluroscopic guidance, IV sedation is not medically necessary.