

Case Number:	CM14-0049628		
Date Assigned:	07/07/2014	Date of Injury:	08/09/1997
Decision Date:	09/08/2014	UR Denial Date:	03/14/2014
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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 53-year-old female who has submitted a claim for Back Pain, Lumbar Degenerative Disc Disease, and Lumbosacral Spondylosis without Myelopathy associated with an industrial injury date of August 9, 1997. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of moderately severe aching low back pain, rated 7/10, alleviated by rest and medication, and exacerbated by all physical activities. Pain radiated to the hips and to both lower extremities. On physical examination, there was no deformity, erythema, soft tissue swelling, ecchymosis, or atrophy of the lumbar spine area. There was tenderness at the paraspinal muscles. Lumbar range of motion was decreased. Straight leg raise was negative while Kemps test was positive bilaterally. Gait was normal. X-ray of the lumbar spine dated November 19, 2013 revealed mild decreased disc space at L3-4 and L4-5 with an anterolisthesis of L5/S1. Treatment to date has included medications; physical therapy; chiropractic care; home exercise program; and bilateral L3-4, L4-5, and L5-S1 radiofrequency ablation (February 2013). Utilization review from March 14, 2014 denied the request for Bilateral Radiofrequency Ablation L4-L5, L5-S1 because there was no documentation of the duration of benefit derived from previous radiofrequency ablation. There was also no report of associated functional benefit and reduction in medication use with the previous procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Radiofrequency Ablation L4-L5, L5-S1: Upheld

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

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, Facet Joint Radiofrequency Neurotomy.

Decision rationale: The California MTUS does not specifically address repeat radiofrequency neurotomy. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that a neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally at least 6 months duration). Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications, and documented improvement in function. In this case, the patient underwent lumbar radiofrequency ablation, which provided 50% relief. However, the records did not specify the duration of pain relief from the said procedure. Furthermore, there was no documentation of adequate diagnostic blocks, improvement in VAS score, decreased medications, or functional improvement. The criteria were not met. Therefore, the request for Bilateral Radiofrequency Ablation L4-L5, L5-S1 is not medically necessary.