MAXIMUS Federal Services

Case Number:	CM14-0090890		
Date Assigned:	09/10/2014	Date of Injury:	09/10/1986
Decision Date:	10/14/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/16/2014

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 Medicine and is licensed to practice in Florida. 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 a 53-year-old female who reported an injury on 09/10/1986 (I also have a date of 09/10/1996), due to unspecified mechanism of injury. The injured worker complained of back pain. The injured worker had diagnoses of lumbar post laminectomy arthrodesis and sacroiliitis. The medications included Ultram, Flexeril, and Ambien. Diagnostics included a nerve conduction study and an MRI. Prior surgeries included a back surgery. The objective findings dated 08/13/2014 to the lumbar spine revealed decreased sensation at the L5-S1 to the left, straight leg raise bilaterally, motor 4/5 RHL bilaterally. Pain upon palpation over the iliac crest on the left. There were 4 well circumscribed trigger points on palpation with a twitch response as well as referred pain. Past treatments included pain medication, a spinal cord stimulator trial, and radiofrequency injections. The treatment plan included an in office pulsed radiofrequency bilaterally cluneal nerves. The Request for Authorization dated 09/10/2014 with submitted documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

In-office pulsed radio-frequency ablation, bilateral cluneal nerves: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 102.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The request for an in office pulsed radiofrequency, bilateral cluneal nerves, is not medically necessary. The California MTUS/ACOEM states 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. The Official Disability guidelines further state facet joint radiofrequency neurotomy is recommended as a treatment that requires a diagnosis of facet joint pain using a medial branch. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at greater than or equal to 50% relief that is sustained for at least 6 months. 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. No more than two joint levels are to be performed at one time. If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks. There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. The clinical notes indicated that the injured worker had a straight leg raise test performed; however, the results were not provided.. The medical documentation did not support the need for bilateral radiofrequency ablation. There was lacked the evidence of measurable functional deficits. As such, the request is not medically necessary.

Fluoroscopic guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 102.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The request for fluoroscopic guidance is not medically necessary. As the requested radiofrequency ablation is not supported by the documentation, the requested ancillary service is also not supported.